Policies, Practices, and Structures Impacting the Health and Care Access of Migrant Children

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POLICIES, PRACTICES AND STRUCTURES IMPACTING THE HEALTH AND CARE ACCESS OF MIGRANT CHILDREN

Research Report 2016

A Central American migrant boy traveling across Mexico stands at a shelter located in Ixteca, Oaxaca.

Prepared for submission to the

Texas Medical Center Health Policy Institute

Abstract

This research report presents the results of an analysis of U.S. laws, policies, regulations, and organizational practices as they relate to children crossing the U.S. border originating from Mexico, Honduras, Guatemala and El Salvador. The analysis was supported by interviews conducted with key stakeholders in academia and policy, health care, and community organizations as well as with people who have migrated to the U.S. from Mexico or Central America. One outcome of the analysis was the identification of specific conditions, factors and upstream determinants that contribute to increasing or decreasing health risks during the migration journey; barriers to quality health and healthcare services experienced by migrant children and their families; and effective strategies to reduce health risks and eliminate barriers to health care among child migrants. Based on the results of the analysis, the research team offers two recommendations to ensure humane treatment of child migrants: (1) ending family detention, including revoking state licensure of existing facilities; and (2) ensuring adequate screening and treatment for physical and mental health, particularly for trauma, which has long term health impacts on children. The report explores policy change strategies to implement the second recommendation in Texas. Few policy windows are currently available; however, a proposed state task force on asylum-seeking children, which would be established under HB 278 (introduced by Rep. Donna Howard [D.48]), provides one leverage point for educating legislators about child migrant health. The results of the research will be used for continued policy development on ongoing policy dialogue. These activities will be implemented in coordination with the Cross-Sector Advisory Board on Child Refugee Health, which was convened as part of the research.

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1 INTRODUCTION

1.1 Background

Human displacement is an unprecedented global humanitarian crisis that impacts children, adults and families. The United Nations Human Rights Commission (UNHRC) reports that in 2015 alone 65.3 million people, nearly half of whom were children, were displaced from their homes by conflict and persecution. According to a 2016 report by the United Nations International Children's Emergency Fund (UNICEF), the number of children who have migrated across borders or have been otherwise forcibly displaced has reached 50 million as of 2015.

There are many reasons why children migrate, often making perilous journeys across great distances. "Some move with their families and others are alone; some have planned their journeys for years while others must flee without warning," states the UNICEF report. An estimated 28 million children were fleeing war and violence in 2015. Those migrating to escape extreme poverty and criminal violence at home may become victims of crime during the journey or forced into sex work or other forms of exploitation along the way. According to the 2016 UN Office of Drugs and Crime Report 28 percent of trafficking victims worldwide are children (including both boys and girls), but that number is as high as 62 percent for those from countries of Central America and the Caribbean.[2]

The moral imperative to address this most vulnerable population is proclaimed in the Geneva Declaration of the Rights of the Child (see Table 1.1). Nearly a century after the declaration, international institutions and government policy-makers are still challenged to live up to these values. The complexity of the issue—including the global, national, and transnational factors associated with child migration; the interaction of multiple sectors and jurisdictions involved with child migrants throughout their journey; and political and ideological differences about the very nature of the phenomenon—creates challenges for developing and implementing policy that lives up to these values.

Table 1.1: Geneva Declaration on the Rights of the Child (summarized)[3]

Principle 1: Child shall enjoy all the rights of the Declaration without distinction or discrimination on account of race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status, whether of the child or the family.
Principle 2: Child shall enjoy special protection and the opportunity to develop physically, mentally, morally, spiritually and socially in a healthy and normal manner and in conditions of freedom and dignity. The best interests of the child shall be paramount.
Principle 4: Child shall benefit from social security, be entitled to grow and develop in health, have special care and protection (to the child and mother, including pre-natal and post-natal care), and have the right to adequate nutrition, housing, recreation, and medical services.
Principle 5: Special treatment provided to a child who is physically, mentally, or socially handicapped, including education and care.
Principle 6: Children shall, when possible, grow up in the care and responsibility of parents and only under exceptional circumstances be separated from a mother. Society and public authorities have the duty to extend care to children without a family and to those without adequate support. State and other assistance shall be paid toward the maintenance of children of large families if desirable.
Principle 7: Elementary education shall be free and compulsory. The best interests of the child shall be the guiding principle of those responsible for the child's education. The child shall have full opportunity for play and recreation.
Principle 8: The child shall in all circumstances be among the first the receive protection and relief.
Principle 9: The child shall be protected against all forms of neglect, cruelty, and exploitation.
Principle 10: The child shall be protected from practices that foster racial, religious, or any other form of discrimination.

The US has struggled with how to address unaccompanied child migrants for decades. The Flores Settlement Agreement of 1997, which sets standards for how the government detains, treats and releases child migrants, was the result of litigation that began in the 1980s, yet it has guided judicial rulings made as recently as 2016 (e.g., Flores v Lynch).

The Trafficking and Violence Protection Reauthorization Act of 2008, which combats global trafficking and imposes penalties for trafficking crimes, was perhaps the culmination of efforts to address this issue. However, it also set the stage for how child migrants are differentially treated depending on country of origin and whether they were unaccompanied when apprehended (see Chapter 2). The lack of consensus and the inability of the U.S. Congress to pass comprehensive immigration reform contributes to ongoing tension in the US. The power to enact and enforce immigration laws lies with the federal government. Yet, state and local authorities can impact the wellbeing of child migrants. States are involved with resettling refugees and licensing facilities that house migrants and some states and municipalities have made medical care more accessible for this population.

How these laws and other policies and practices shape the health of child migrants is the subject of this report. This research report is one component of an ongoing research project that seeks to support the development and implementation of policies and practices that impact the health and wellbeing of child migrants. That ongoing research is designed to facilitate ongoing dialogue among representatives across the differing sectors addressing child migrant health. This report focuses mainly on child migrants fleeing Central America and Mexico, and its emphasis is on implementable policy in Texas.

Table 1.2: Basic Definitions

Migration: The movement of a person or a group of persons either across an international border or within a state. As such, migration encompasses any peoples' movement, no matter its length, composition or cause.[4]
Unaccompanied Alien Children: Under US law, children who: lack lawful immigration status in the United States, are under the age of 18, and are without a parent or legal guardian in the United States or without a parent or legal guardian in the United States who is available to provide care and physical custody.[5]
Refugee: Under United States law, someone who is (1) located outside of the United States; (2) of special humanitarian concern to the United States; (3) demonstrates that they were persecuted or fear persecution due to race, religion, nationality, political opinion or membership in a particular social group; (4) not firmly resettled in another country; and (5) admissible to the United States[6] (This report includes statistics for child refugees when specific figures are unavailable for child migrants.)
Asylee: An alien in the United States or at a port of entry who is found to be unable or unwilling to return to his or her country of nationality, or to seek the protection of that country because of persecution or a well-founded fear of persecution. Persecution or the fear thereof must be based on the alien's race, religion, nationality, membership in a particular social group or political opinion. For persons with no nationality, the country of nationality is considered to be the country in which the alien last habitually resided. Asylees are eligible to adjust to lawful permanent resident status after one year of continuous presence in the United States.[7]
Child Migrant: A person under age 18 who crossed the US border without immigration authorization independent of cause. This includes unaccompanied alien children as well as children who crossed the border with a family member who also lacked immigration authorization. (This report focuses on child migrants from Central America and Mexico, many of whom crossed the US border to seek asylum.)
Unauthorized Immigrants: "Unauthorized immigrants include those who enter the country without legal permission and those who overstay their visas."[8]

1.2 Purpose of this report

This report presents findings and recommendations from a study of the health risks and care access of children fleeing Central American and Mexico. Funded through a grant from the Health Policy Institute of the Texas Medical Center (TMC), the research aims to uncover government policies, agency practices and environmental factors associated with the health of child migrants from Central America and Mexico and their ability to receive adequate healthcare in the U.S. The research included an assessment of current laws, regulations and organizational practices vis-à-vis child migrants along with interviews with child migrant families and decision-makers involved with processing detained children. The research team consisted of cross-disciplinary practitioners, including a health economist, an anthropologist, a medical humanist, and three pediatricians. In addition to the cross-disciplinary team, the research partners convened a cross-sector advisory board on child refugee health. The advisory board is comprised of experts in the field of immigration and migrant health.

The research facilitates the development of policy alternatives consistent with human rights standards. It is informing an ongoing policy dialogue among relevant stakeholders to improve child refugee health and access to medical care. The use of "health" in

this document refers to both physical and mental health. The use of children in this document refers to young people under 18 years of age. We use the term "child migrant" rather than "refugee" as a neutral term recommended by the Pan American Health Organization in its report on migrant health (see Table 1.2). Our focus is on child migrants as defined through a human rights lens—that is, anyone who is fleeing extreme violence, insecurity and/or displacement. The research has implications not only for child migrants from Central America and Mexico, but for all displaced children who suffer the consequences of extreme trauma and violence.

The research is designed to inform ongoing dialogue among a wide variety of stakeholders that will be convened to discuss policies and practices to address child migrant health. The research team's cross-sector advisory board on child refugee health began the process for constructive dialogue among various stakeholders and the dialogues have continued beyond panel meetings. Research team members and cross-sector members met twice throughout the lifespan of the project, exchanging ideas and assisting with other relevant research and advocacy projects beyond the TMC grant. We anticipate continuing to convene this advisory board well beyond the TMC grant period.

1.2.1 Structure of this Report

Given the complexity of child migrant health as a policy issue, this research and report is limited in scope. It aims to:

- Uncover issues relevant to the health of child migrants (both short and long-term)
- Identify one core state policy that could be recommended to Texas policy-makers and potentially implemented within three to five years
- Identify policy windows and other opportunities for placing the recommendation on Texan policy-makers' agendas

Local and state policies to address the health of child migrants depend on federal immigration law. The next chapter discusses how federal policy and recent court cases have shaped how child migrants are *supposed* to be treated under the law. It provides a foundation for understanding (1) why the US treats child migrants from Mexico differently from child migrants from Central America; and (2) why unaccompanied child migrants are treated differently from child migrants in a family unit. More importantly, it exposes some of the weaknesses in the system that increases health risks yet reduces the availability of needed health services for this population. Multiple perspectives from the qualitative research presented in Chapters 3 and 4 corroborate these weaknesses. Chapter 3 presents the data and methodology and chapter 4 presents the results. Our results provide support for the core policy for addressing the health of child migrants in Texas. In chapter 5, we discuss the core policy and two potential policy windows for implementation. The chapter concludes with a discussion of future activities to address migrant health in coordination with the cross-sector advisory board on child refugee health.

1.3 Why study the health of child migrants?

Migration and health, broadly defined as physical and mental health as well as an overall state of well-being, are closely connected. For the population of child migrants from Mexico and Central America, health and access to care impact and are impacted by the process of migration. The search for health, safety and security is a key cause of migration. For unauthorized migrants, the journey has significant impacts on health and in some cases has resulted in deaths. They endure a difficult and dangerous journey toward the U.S. Central American migrants must cross the entire nation of Mexico where they face the risk of accident, injury, assault, sexual violence or other threats. Living as an unauthorized immigrant, or being held in immigration detention for either short or extended periods of time, can impact access to healthcare and therefore overall physical and/or mental health. Even though many are fleeing violence, Mexican and Central American migrants are not legally defined as refugees they must seek asylum after they arrive.

1.3.1 Long-term effects of trauma

An emerging science in psychiatry and neurobiology provides evidence that the trauma child migrants experience during their journey could have long-term impacts on their physical and mental health outcomes well into adulthood. The groundbreaking CDC-Kaiser Adverse Childhood Experience Study, for example, discovered a strong association between childhood trauma and chronic disease as well as mental illness and substance abuse across the entire lifespan.[9, 10] Adverse childhood experiences (ACEs) include stressful and traumatic events such as abuse, neglect, or growing up in a

family situation characterized by substance abuse or domestic violence. Subsequent research demonstrates a biological mechanism for this phenomenon.[11] Essentially, ACEs are toxic stressors that negatively alter biological systems, including a developing child's brain.[12, 13] Many ACEs are also risk factors for post-traumatic stress disorder (PTSD), a disabling condition that can become chronic.

1.3.2 PTSD in child migrants

Child migrants exposed to trauma during their journey may also have a specific diagnosis of PTSD. PTSD statistics are generally unavailable for all child migrants. However, PTSD prevalence rates among child refugees offer a proxy for PTSD among child migrants, particularly those migrants who flee violence or who are victims of crime and trafficking. Prevalence estimates for adolescent refugees range from 11 percent to 75 percent with variation due to differences in the nature of and exposure to trauma and resettlement experience.[14-16] How PTSD is manifest in child migrants is also unclear, but likely is represented by a spectrum of externalizing and internalizing behaviors from anxiety disorders and aggressive behaviors to mood disorders and disrupted cognition. In this way, it may be challenging for those encountering these young children to accurately assess their needs, especially in emotionally charged and pressured situations.

1.3.3 Socioeconomic impact of trauma

ACEs have an impact not only on the children themselves, but on society as a whole, including the costs of care as well as the cost of decreased productivity. Growing up in an adverse and neglectful situation is clearly associated with life-long mental health implications.[17, 18] Fang *et al*. (2010) estimate an average lifetime cost per victim subject to child abuse and neglect of $229,970 (in 2016 dollars). This figure includes added child healthcare, welfare and special education costs as well as added criminal justice, adult healthcare and productivity losses that occur over a lifetime. [19] Increasing evidence suggests the need to take into account ACEs among child migrants and intervene early on. Because many child migrants will obtain immigration relief and become eligible for government services, policy-makers should consider the long-term implications of child migration on their own states or municipality's health and human services system budgets.

Policy-makers should consider the impact of ACEs, trauma and PTSD in their treatment of child migrants. Childhood and adolescent trauma can lead to difficulties in school and increase the risk of dropping out of education, thereby decreasing the likelihood of meeting the requirements for rewarding and prosperous employment.[20] Proper funding for mental health services, schooling and school-based services for undocumented minors is seen by the American Psychiatry Association as an investment in a better future citizenry.[21]

Not only are child migrants exposed to many stressors associated with PTSD, but the experience of detainment may itself be a stressor. For children and adolescents, detainment can mean loss of control, forced separation from family and relatives and detachment from the world with which they are most familiar (regular community settings, spiritual practice). Detention is particularly traumatic for children who are unable to comprehend reasons for their detainment.[22] The detention of children was found to increase the risk of acquiring depression, anxiety and PTSD symptoms.[23] The long-term effects of detainment on child migrants can include higher rates of suicide, suicidal attempts, and self-harm.[24]

1.4 Texas and child migration

Texas is America's fulcrum point for addressing human displacement in the Americas. Texas is a state with a long history of migrants crossing the border from both directions, and the Houston metropolitan area, the most ethnically diverse in the nation, has a history of resettling refugees.[25] If Houston were a country, it would rank fourth in the world for refugee resettlement. More recently, Texas is a destination for child migrants, many unaccompanied, fleeing violence and poverty from Mexico and Central America. In 2016, more than 6,000 unaccompanied child migrants were released to sponsors in Texas; this figure is the second highest for any state and represents 12 percent of the national total.[26] In 2014 alone, over 4000 unaccompanied child migrants from Mexico and Central America were placed with sponsors in Houston and surrounding communities.

The recent presidential election highlighted immigration as a key issue, and the new administration has placed immigration at the top of its policy agenda. In Texas, the politics of immigration include varied opinions regarding the resettlement of refugees as well as concern over the conditions of Texas facilities housing of child migrants. These facilities are under the authority of the U.S. Department of Health and Human Services and the U.S. Department of Homeland Security. Immigration advocates have successfully challenged the housing of child migrants in these facilities as not consistent with federal law governing the appropriate treatment of child migrants (see Chapter 2).

Our research, conducted in the context of this politically contentious environment, could help guide Texas policy-makers well into the future. However, the accounts of anti-immigrant sentiment in Texas, as many informants of this study report, suggests significant challenges for the promotion of immigrant health. For example, many cited fear of deportation and being stigmatized as undocumented as reasons for not seeking care when needed (see Chapter 4).

How Texans respond to the issue of child immigrants has the potential to set the tone for the rest of the nation. The sheer number of child immigrants who could be resettled in Texas will undoubtedly have significant social and economic impact on the state. But more important to the nation is the perceived level of humanity with which Texas handles the care of this vulnerable population. For example, some states have made Medicaid and other social services available independent of legal status, while Texas, which has the highest rate of uninsured individuals in the country, has not expanded Medicaid under the Affordable Care Act.

2 International and Policy Context

2.1 Introduction

Understanding the context in which child migration occurs in the Americas is important for understanding the risks child migrants face throughout their journey. Our research discusses some of the causes of immigration to the U.S., considers how those causes are related to U.S. domestic and foreign policy, and how such causes impact the health risks of this population. In addition, U.S. immigration laws – some of which have been challenged in ongoing court battles – govern how child migrants are treated in the U.S. (see Section 2.4.2). Nevertheless, there is growing consensus about how child migrants should be treated. The chapter concludes with a discussion of ethical considerations in developing policies to address the health and health access of child migrants.

2.2 Migration in the Americas

World population statistics indicate that more than one billion people around the world (one out of every seven) are migrants.[27-29] According to the 2009 estimate of the United Nation Development Programme (UNDP), migration includes over 740 million internal migrants who move within a country's borders.[30] The International Organization of Migration (IOM) estimates 244 million international migrants in 2015.[i] [29] These numbers account for the movement of people regardless of length of stay (permanent or temporary or unpredictable) or of nature of movement (forcibly or voluntary displacement).[27-30]

At the end of 2015, the number of individuals who were forcibly displaced around the world due to conflict or violence reached 65.3 million, a nearly 10 percent increase over 2014 (59.5 million). This includes 21.3 million refugees, 3.2 million asylum seekers and 40.8 million internally displaced people.[31]

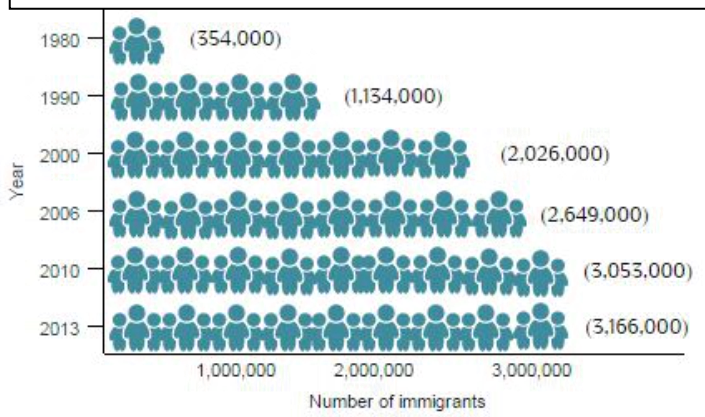
Demographic characteristics of international migrants change over time. Women currently represent 48 percent of international migrants.[29] The majority of international migrants (150 million or 72 percent)[32] are of working age, while 37 million (15 percent) are less than 20 years old.[29] The majority of international migrants (71 percent) emigrate from South and Central America, more than half of migrants (51 percent) immigrate to another country in the region, and almost half of migrants (49 percent) immigrate to the north.[33]

[i] "*People residing in a country other than their country of birth"* – the definition of the international Organization of Migration (IOM).[27]

The last 15 years witnessed a remarkable and unprecedented increase in human mobility within the Americas as the immigrant population increased from 34 million to 61 million between 1990 and 2013. This 78 percent increase is more than double the rise observed in all other parts of the world.[34] The U.S. was the choice of destination for the majority of international immigrants within the Americas. In 2013, the number of immigrants in the U.S. reached 45.8 million.

In some respect, the number of unauthorized migrants entering the U.S. has stabilized in recent years. According to U.S. Border Patrol data, the number of Mexicans detained at the border is the lowest it has been in 50 years.[35] As the Pew Foundation reports, "And for the first time since the 1940s, more Mexican immigrants – both legal and unauthorized – have returned to Mexico[36] from the U.S. than have entered."[37] At the same time, the number of unaccompanied and family migrants from Central America has increased at the U.S.-Mexico border, especially in Texas. These migrants are primarily from the countries of Guatemala, El Salvador and Honduras. A significant number of these migrants from Central America are children and families. A total 68,000 unaccompanied children (up to 17 years of age) were detained during 2014 after crossing the border.[38] U.S. Customs and Border Protection (CBP) reports a significant increase of the numbers from El Salvador, Guatemala and Honduras rising from an average of 1,000 children from each country in 2009 to between 16,000-18,000 per country in 2014. CBP also reported an average of nearly 15,000 children immigrating from Mexico each year during the same period.[38]

Figure 2.1: Central American Immigrant Population in the United States, 1980-2013



2.3 Causes of the emigration from Mexico and Central America

2.3.1 Poverty and inequality

Contemporary emigration from Mexico, Honduras, El Salvador and Guatemala is a result of existing poverty and inequality, neoliberal economic reforms, and on-going violence in the region. A 2016 report on health and migration from Mexico and Central America notes that:

> *"The migratory process in the Central America-Mexico-United States corridor is determined strongly by the inequality and poverty that exists in the region. It refers to a trend that will continue as long as inequality and poverty increase inequalities between Central American and Mexico as fundamentally expelling countries and the United States as a fundamentally receiving country remains. Migration, in conditions of inequality and poverty, has high costs for those who are forced to be involved in it and leads also to high benefits for those who make use of the labor (cheaper and without benefits) whose availability increases in these conditions."*[39]

> *"Refugees, people in need of protection, and migrants—including unaccompanied minors—will continue to leave the Northern Triangle countries in record numbers until their governments can implement policies that actually reduce violence, insecurity, and poverty, tackle corruption, and strengthen weak institutions"*
>
> Commentary, World Office of Latin America (Advocacy for Human Rights in Americas)[1]

Despite steady economic growth, limited success in the reduction of extreme poverty, and limited success in the reduction of income inequality during the last decade[34, 40, 41], Latin America and the Caribbean remain the world's most inequitable region.[41] For example, the richest 10 percent of the population owns 71 percent of the region's wealth.[40] In 2014, the World Bank reported a poverty rate of 53 percent for Mexico, 62 percent for Honduras, 59 percent for Guatemala, and 31 percent for El Salvador. Neoliberal reforms have been implemented in these nations under pressure from international lending agencies such as the World Bank and International Monetary Fund. Beginning in the 1980s, these reforms required significant cuts in social services, such as cuts in health care, in order for the governments to receive financial support.

Generally, the Latin America and Caribbean region provides an illustrative example of how the impact of severe economic inequality can negatively impact economic growth, peace, social stability and social cohesion.[40] Income inequality is often associated with unequal access to education, healthcare, political participation and political power.[42] Fajnzylber, *et al*. (2000) concluded that there was a strong positive association between income inequality and the incidence of crime[ii], including both robbery and homicide.[43]

Most migrants from both Mexico and the northern triangle countries (NTCs) of Guatemala, Honduras and El Salvador belong to a lower socioeconomic stratum. They seek a better life in their country of destination and work to send remittances home. Remittances are not only a substantial means of support for their family members in the countries-of-origin, but may also be viewed by governments as a significant source of foreign currency.[44]

The connection between impoverishment in Mexico and Central America and US trade policies is one of several ways in which US trade policies connect to the reasons for emigration. For example, the North American Free Trade Agreement (NAFTA) was criticized as a direct cause of the loss of 1.3 million farm jobs in Mexico. This loss resulted from the inability of local farmers in Mexico to compete with highly subsidized U.S. crops because NAFTA removed trade tariffs and U.S. companies exported grains and corn at lower prices.[45] Emigration from Central America to Mexico is unlikely to lesson until these economic conditions are ameliorated. As the World Office of Latin America (WOLA) states, *"*Refugees, people in need of protection, and migrants—including unaccompanied minors—will continue to leave the Northern Triangle countries in record numbers until their governments can implement policies that actually reduce violence, insecurity, and poverty, tackle corruption, and strengthen weak institutions.*"*

2.3.2 Armed groups violence, insecurity and lack of means of protection

Pervasive violence is a major cause of emigration from NTCs, well known as one of the most violent regions in the world (see Table 2.1). Guatemala and El Salvador have a history of civil wars beginning in the 1960s. In Guatemala, an estimated 200,000 were killed in the civil war lasting from 1962-1996 and thousands sought refuge in neighboring Mexico or the United States. In El Salvador, more than 70,000 were killed from 1980-1992, with tens of thousands leaving the nation, many of them migrating to the U.S. During the Cold War, the United States provided significant support to the repressive military regimes of Guatemala and El Salvador, with $1.5 million a day going to the Salvadoran government under the Reagan administration in 1982.[iii]

Table 2.1: Share of Latin America and Caribe region of homicide among children

Region	No. of homicide victims	Homicide rate per 100,000
Latin America and the Caribbean	**25,400**	**12**
West and Central Africa	23,400	10
Eastern and Southern Africa	15,000	6
South Asia	15,000	2
Middle East and North Africa	3,700	2
Countries outside of these regions	3,800	2
Central and Eastern Europe and the commonwealth of Independent States	1,500	1
East Asia and the Pacific	7,100	1
World	**94,900**	**4**

Source: UNICEF report "Hidden in Plain Sight: A statistical Analysis of Violence against Children" based on WHO Global Health Estimates Summary Tables: Deaths by cause, age, sex & region, 2012, recalculated according to UNICEF's regional classification.[50]

The legacy of these decades-long wars contributes to the current violence in these countries, as they become increasingly impacted by organized, armed, and criminal gangs.[1, 46]

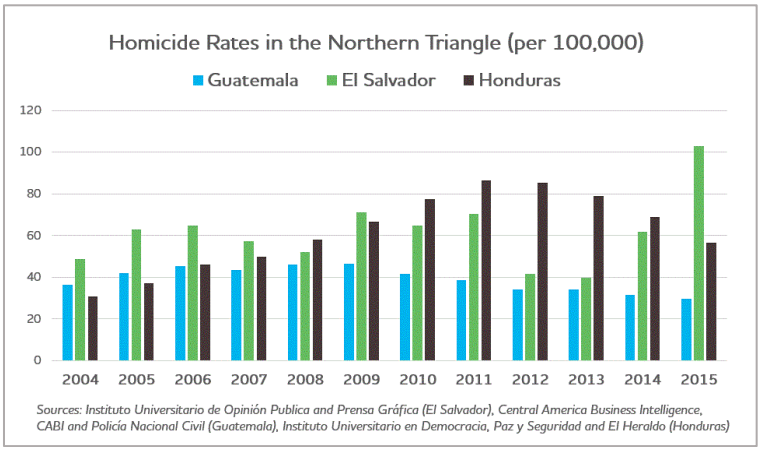
Organized crime grew substantially after the civil wars. In 2012, the UN Office on Drugs and Crime reported that gang members numbered 22,000 in Guatemala, 20,000 in Salvador and 12,000 in Honduras.[47] An analysis produced by the Council on Foreign Relations notes the common thread of violence among all NTCs, citing: "the proliferation of gangs,

[ii] It is unclear whether the reverse is true. For example, El Salvador experienced a reduction in income equality (at least as measured by the Gini Coefficient) during the 2000s (the fifth largest decline according to the World Bank), yet gang violence continued during this period of declining inequality. If violence is inelastic to economic growth and increased income equality, as this suggests, preventing the introduction of violence.

[iii] For a more in-depth analysis on the history of violence in Central America, see Joaquin M. Chavez, "An Anatomy of Violence in El Salvador," North American Congress on Latin America, https://nacla.org/article/anatomy-violence-el-salvador.

the region's use as a transshipment point for US-bound narcotics, and the high rates of impunity." The analysis implicates U.S. drug policy as encouraging a high demand for drugs from Central America and U.S. deportation of "an estimated hundred thousand immigrants [often gang members] with criminal records [typically involving guns] to Northern Triangle countries."[48]

Figure 2.1: Homicide Rates in the Northern Triangle



While homicide rates continued to slowly decline in Honduras and Guatemala, the last year witnessed an exponential increase in the murder rates in El Salvador based on the official statistics of the governments (see Figure 2.1). In 2015, the homicide rate reached 103 per 100,000 inhabitants with a 70 percent increase in comparison with 2014. In Honduras, it declined to 57 per 100,000 inhabitants in 2015 in comparison with 69 per 100,000 inhabitants in 2014. In Guatemala, it also declined to 29.5 per 100,000 inhabitants in 2015 in comparison with 32 per 100,000 inhabitants in 2014.[1, 44] For comparison the national murder rate in the U.S. in 2015 was 4.9 per 100,000 people.[49] According to a report published by UNICEF in 2014 on violence against children, Latin America and the Caribbean had the highest child homicide rate, 12 per 100,000 persons, which is three times the world average of 4 per 100,000 people.[50]

Extortion is another form of the violence in Central America. *La Prensa*, a Honduran daily newspaper, provided an evidence-driven estimation of extortion fees that reached $400 million (US dollars) on an annual basis.[51] The National Council of Small Business in El Salvador (CONAPES) conducted a study with 425 micro and small business participants. It concluded that 70 percent of the participants were victims of extortion; however, 65 percent of the victims did not complain out of fear of reprisal.[52]

In El Salvador, Guatemala and Honduras, people living in poor communities and marginalized neighborhoods may face death threats if they witness a crime, refuse to join a gang or try to leave a gang. Women and children in these communities are subject to different forms of violence by local gangs including abuse, extortion, rape and murder.[1, 46] In their systematic review, Wirtz*, et al*. (2016) concluded that high rates of violence during childhood exist throughout the Latin American and Caribbean region. In El Salvador, 42 percent of women and 62 percent of men reported experiencing physical violence before age 15, based on a study with a nationally representative sample. In Guatemala and Honduras, 5 percent and 8 percent, respectively, of adult women reported experiencing sexual violence in their childhood. The review suggested that even the reported 'high' rates of violence during childhood underestimate the real prevalence due to the associated stigma and dominant societal morals.[53]

In most Central American countries, particularly NTCs with high levels of violence practiced by organized criminal groups, there is a lack of effective strategies for protecting adults and children. This is especially true for those who live in poor communities. Potential victims of violence, extortion, sexual abuse and murder in NTCs hardly receive any protection from the authorities. On the contrary, in many occasions, victims of violence do not report these crimes to the police because they wish to avoid any further punishment by gangs. Law-enforcement institutions in NTC countries suffer from underfunding and poor governance, which can open doors to corruption. There are numerous examples of police officers who are complicit in or silent about criminal activities.[1]

2.4 U.S. immigration policies

2.4.1 The international context

While escaping poverty and seeking a better standard of life continues to represent a legitimate cause of emigration, migration from Central America is pervasively violence-driven. Migrants, especially women and children, seek protection from violence, both domestic and that from by armed groups.[1, 44, 47] However, when authorities in receiving countries

like Mexico and the U.S. do not recognize anything other than economic reasons for migration, these migrant groups are unlikely to receive deserved legal status.[44]

In his report to the General Assembly of 2008, United Nations Special Rapporteur on Human Rights of Migrants Jorge Bustamante criticized U.S. immigration policies for their lack of adherence to international treaties and their failure to respond to the human rights of immigrants who are living in the country. He suggested the need for comprehensive and better coordinated policies that align with international regulations and obligations. [54] Human Rights Watch specifies three items as a suggested policy agenda for the attention of policy-makers and legislatures: (1) reforming the 'outdated and ineffective' detention policies; (2) reforming the deportation policies and (3) reconsidering labor regulations for immigrants.[55]

Migrants who cross the Mexico-U.S. border, including minors, are subject to mandatory detention pending a decision on whether they will be deported and then pending their immigration procedures. Stricter detention policies, shaped by the 1996 Anti-terrorism and Effective Death Penalty Act (AEDPA) and the 1996 Illegal Immigration Reform and Immigrant Responsibility Act (IIRAIRA), resulted in exponential increase in number of detainees from a total of 8,500 in 1996 to 16,000 in 1998. Mandatory detention of non-citizens while pending immigration procedures is a violation of the constitutional right to due process enforced by the Fifth Amendment. Under the policies of mandatory detention, migrants lose their opportunity to prove their suitability to be released. However, in non-immigration related circumstances, the courts have prohibited mandatory detention without a proof of danger or flight risk. Federal courts in New York, Massachusetts, Illinois, Michigan, Minnesota, Colorado, Oregon and California used the same argument in dealing with immigration.[56]

2.4.2 Key federal laws and court cases shaping the treatment of child migrants

A child migrant's experience in their immigration journey depends in part on how the courts interpret federal law. Prior to the passage of the Patriot Act, the Immigration Naturalization Service combined both policing and adjudication roles. The Patriot Act separated these functions. Whereas the apprehension, processing and detainment of child migrants is overseen by Immigration and Customs Enforcement (ICE) within the U.S. Department of Homeland Security (DHS), the housing of children and the support services offered are provided by the Office of Refugee Resettlement (ORR) in the U.S. Department of Health and Human Services (HHS).

Child migrants from Central America and Mexico have different opportunities to seek immigration relief, and unaccompanied child migrants are treated differently from child migrants who are detained with family. The William Wilberforce Trafficking Victims Protection Reauthorization Act (TVPRA 2008), which passed Congress with unanimous consent in the last year of the George W. Bush administration, set the stage for the current controversy in relation to unaccompanied child migrants.

TVPRA 2008 requires DHS to place child migrants within 72 hours with ORR so that they can be placed in non-secured facilities. ORR is responsible for providing shelter and health care among other needed services. ORR seeks sponsors in the community to which many of these children are released while awaiting their case before an immigration judge. Sponsors have basic requirements, with the most important being to ensure the child appears in immigration court.

In an effort to address the unexpected increase in the number of children apprehended at the border, ICE has treated unaccompanied child migrants different from child migrants apprehended with a parent or other family member. In Texas, ICE worked with the state government to house child migrants in family units within what is known as family detention. The two family detention facilities in Texas are operated by two private companies (the GEO Group and Corporate Corrections of America), while the family detention facility in Berks, PA is operated by the county government. The family detention facilities are required to provide health services to their residents.

Numerous reports of maltreatment in these facilities have led immigration rights groups to call for their closure. Two such reports are "End Immigration Detention of Children" and "The Dangers of Detention." "End Immigration Detention of Children" is an evidence-driven campaign that calls on governments to adopt alternatives to detention.[24] The Justice Policy Institute published "The Dangers of Detention," encouraging an end to the practices as well.[23]

The Flores Settlement Agreement initially set standards for the treatment of child migrants after apprehension by DHS. Two more recent cases, Flores v Lynch[57] and Grassroots Leadership, Inc. v Texas DFPS and CCA and GEO,[58] further

clarify how child migrants should be treated when in custody of federal officials. The first rules that child migrants accompanied by families must be treated like the unaccompanied child migrants. The second was a ruling by a state court that invalidates the licenses of private operators CCA and GEO for non-compliance with minimum standards of operations.

Generally, child migrants from Central America and Mexico who demonstrate that they were a victim of crime or trafficking must be given the opportunity to seek asylum. While in custody, their health risks and access to healthcare is governed by federal law. Child migrants with legal status have access to health insurance if they meet general eligibility requirements (e.g., ACA market plan or Medicaid), but until they receive legal status, they have little health care options available outside of emergency Medicaid or services through a community health center, migrant health center, emergency room or school health clinic (see Chapter 5).

2.5 Humanitarian considerations

Immigration advocates across the U.S. and globally continue to shed light on the treatment of child migrants and the need to ensure they are treated humanely and ethically. Multiple experts from governmental and non-governmental agencies formed the "Interagency Working Group on Unaccompanied and Separated Children" with funding and support from the MacArthur Foundation. In 2016 the Working Group released *Framework for Considering the Best Interests of Unaccompanied Children*. This report recommends the "best interest of the child" framework as a practical, step-by-step guide for considering the best interests of individual children within the confines of existing law. This guide has the potential to inform policy-makers from a wide variety of sectors, not just those that deal directly with child health or children generally. This health in all policies approach to the treatment of unaccompanied children may prove promising if agencies from multiple sectors agree on the framework.

The Department of Homeland Security has taken a similar health in all policies approach. This past year it convened an inter-agency working group to consider family detention, its impact on children and potential alternatives. It too recognizes that detention may not be the most appropriate route to take.

3 METHODOLOGY

The research findings presented in this and the next chapter provide an examination of the experience of child migrants and their journey through the U.S. system. Using qualitative research methods, multiple perspectives facilitate a better understanding of the policies, practices and structures impacting child migrants through a health lens. The results address many of the issues detailed previously in this report.

Qualitative research methods were used to inform a holistic understanding of child migrant health risks and healthcare access barriers. The research combined a systematic review of literature and existing policies and practices with qualitative analysis of primary data. Primary data included: focus group discussions (in-person), structured interviews (via phone calls or video conferencing), life histories (in-person), and a participatory rapid assessment (in-person). The team designed an interview script that allowed for probing for more elaborate answers from key informants and gave study participants a better opportunity to be more reflective. In-person interviews and focus groups occurred in southeast Texas. All data collection techniques were designed and implemented in English or Spanish as appropriate.

3.1 Study population, sampling and sampling procedures

The research adopted a purposive sample of participants belonging to four categories of stakeholders: 1) migrant children and their families; 2) professionals (at local, state, and federal levels) involved with processing child migrants or developing and/or studying the regulations or policies involving child migrants; 3) health providers who have experience working with child migrants (e.g. prison health, community health centers, and other organizations providing care to child migrants); and 4) community organizations that offer health, legal, educational and other services to child migrants.

The research team used the following recruitment strategies:

- Maximum variation sampling: By selecting study participants from each of the four categories that represented *different* points of view, perspectives and experiences, which thus contributed to a richness of data
- Typical case sampling: By attempting to avoid recruiting extreme or outlying 'cases' (e.g. informants with extremely unusual opinions or atypical experiences). This provided the opportunity for the study findings to be acknowledged and understood as relevant in policy dialogues
- Snowball sampling: By relying on the study participants contacted initially from each category to nominate others. However, nominations were carefully studied in an effort to promote diversity in the sample

Table 3.1

Data collection method	Number
▪ Executive interviews	14
– Policy-makers and academic	4
– Health Providers	2
– Community Organizations	8
▪ Focus group discussions with migrants and families	2
▪ Life stories with migrants	2

As qualitative research, the final sample size was determined by the ability to obtain diverse perspectives and triangulate the data to uncover discrepancies and consistencies sufficient to meet the different aspects of the study objectives.

3.2 Data collection

Recruitment for the migrant children and their families and all Spanish language interviews and translation (see below) were allocated to the University of Houston Clear Lake partner. The recruitment activities for migrant children and families included networking with a wide range of organizations that serve the study population or support migrants from Central America or Mexico. Organization engagement efforts included sharing information about the research project requesting the organization's support in locating participants who would be willing to share their stories. Information from the many service providers in the region provided important context for the research project.

For the structured interviews, the research team developed a sample frame that had a mix of experts, migrants, providers, professionals and community based organization managers (see Table 3.1). During ongoing recruitment, the team attempted to ensure a mix of interviewees from these categories.

All the interviews included questions about health, health risks, healthcare access and health-seeking behaviors related to the migration journey. These include: country of origin, immigration journey, apprehension and detention, and the community.[iv]

3.2.1 Focus group discussions (FGDs)

Focus group discussions (FGDs) were used to collect data related to the three specific objectives from the families of migrant children (17 years or younger). Two FGDs were organized (consisted of all female adults with childcare for children). The gender-based division served to listen to the experiences of women who had crossed the border with children, who were detained with their children, and/or sent for their children from Mexico and Central America. [Because of a lack of facilities, men in Texas are not detained with children]. Each FGD included four to five adult participants. The FGDs were moderated by an experienced facilitator based on pre-developed guidelines (including questions and probes) and all sessions were digitally recorded after permission was granted by participants. The recordings were transcribed in Spanish, translated to English.

3.2.2 Structured interviews (via phone calls or video conferencing)

Structured interviews were used to collect data related to the three specific objectives from: 1) professionals (at local, state, and federal levels) involved with processing child refugees or developing/studying the regulations or policies involving child migrants; 2) health providers who have experience working with child migrants (e.g. prison health, community health centers, and other organizations providing care to child migrants); and 3) Community organizations that offer health and non-health services to child migrants. We interviewed four informants from category one (professionals), two informants from category two (health providers) and eight informants from category three

[iv] In addition to interviews, two members of the research team conducted a site visit to the family detention center in Dilley, Texas.

(community organizations) for a total of 14 interviews. The interviews lasted approximately one hour each, with some as short as half an hour, and several lasting beyond an hour and a half. In almost each interview (13 of 14), two researchers asked the questions and recorded detailed notes on the call. None of these interviews were tape recorded. (See Appendix 1.)

The majority of the stakeholders, especially those in the category of community organizations, have years of experience working with the child migrant population and hence, have first-hand experience working with hundreds of migrant children and their families. In addition, many of the interviewees had significant experience working with professionals that process child migrants and were able to discuss their observations.

3.2.3 Life History (in-person)

Life histories were used to document in detail the case of particular child migrant families. The interviews document exposures to health risks and the barriers to healthcare access, particularly in the U.S.. The interviews were carried out by a member of the research team who had experience with qualitative research approaches. The interviews were based on pre-designed guidelines and gave the interviewee opportunities to share details about different stages of her family's lives. One interview was recorded via notes after permission was granted; a second was recorded via digital tape-recorder.

3.2.4 Participatory rapid appraisal (PRA)

Combining several methods and focusing on empowerment, the participatory rapid appraisal (PRA) is an increasingly used approach to encourage a vulnerable group within certain localities to share, discuss and analyze their problems and identify solutions. Two PRA sessions were organized, which took place during the FGDs to identify and plan for the implementation of short-term strategies under objective three. The PRA is considered a combination of data collection and action. The PRA was digitally recorded after receiving permission from participants.

3.2.5 Limitations

The political context regarding immigration and refugees in the United States had a significant impact on the data collection. Significant anti-immigrant and xenophobic acts were evident at a state and national level during the research project. In the 2016 presidential campaign, the Republican nominee proposed building a wall between the U.S. and Mexico, supported deportation of all undocumented immigrants, and spoke of refugees as a security threat. At the state level, in September 2016, Texas Governor Gregg Abbott sent a letter to the Office of Refugee Resettlement announcing plans to withdraw from the program because of the "danger" posed by some refugees and supposed security threats. Harris County, Texas has taken the lead in the number of deportees in the country (*Texas Tribune*, Tran-Thu Duong, November 2016). This county-level action was supported by implementation of Section 287(g) of the Immunization Naturalization Act, which authorizes DHS to deputize selected state and local law enforcement officers to perform functions of deferral agents. In this context, migrants and their families were hesitant to speak about their experiences related to migration and health and key stakeholders were hesitant to put the research team in touch with migrants and their families. Even though researchers explained that names would not be used in the study, potential participants were fearful of placing themselves or those they work with at risk by sharing stories about their journey to the U.S. and experiences in detention.

3.3 Data management and analysis

The research team transcribed all survey data as needed for analysis. This included data from FGDs, semi-structured interviews, the life history interview, and the PRA. Data management included transcription of notes, categorizing the responses obtained by each data collection method according to the study aims, open coding the responses under each aim, and comparing responses of different categories of study participants. ATLAS.ti, a qualitative data analysis software package, was used to triangulate information from the multiple formats and informants. Analysis started with researchers individually immersed in the data by reading through the data at least three times. Each transcript was then open coded by two researchers and codes were assigned to meaningful text segments. Codes were compared and revised during analysis until themes emerged. Once all transcripts were coded, the researchers discussed dissimilar

codes until consensus was reached. Data and labels were similarly coded by all researchers. Codes and labels that were dissimilar were discussed until agreements were reached and final themes summarized to represent the findings. Digitally recorded data collected in Spanish was transcribed in Spanish, and then translated to English before coding. Data collected by notes in Spanish was translated to English before coding.

3.4 Ethical consideration

Ethical clearance was obtained before the study commenced by writing and submitting a research protocol to the University of Houston-Clear Lake Committee for the Protection of Human Subjects; the proposal was later submitted to the University of Texas Medical Branch (UTMB) Institutional Review Board (IRB). All participants were provided with detailed information about the study. Each participant who agreed to participate was asked to verbally consent to the interview. The consent forms were translated and presented to study participants in Spanish language as needed. The data collection methodology included informed consent and confidentiality. All interviewees were kept confidential by creating unique identifiers. The unique identifier spreadsheet, which contained identifying information, was encrypted and only housed on one research team member's computer (e.g. was not emailed or uploaded to a shared drive). The names of the migrants and their families were never recorded anywhere. Any identifying information from the interviews of the migrants and their families (such as the name of a village of origin) was not recorded.

4 FINDINGS

The research project focused on migrants from the countries of Mexico, El Salvador, Guatemala and Honduras. Questions asked focused on the most pertinent issues facing migrants, conditions in the migrant's country of origin, the journey from Mexico and Central America to the US, detainment in the US, and living in US communities.

4.1 Most pertinent issues

The lack of mental health services and lack of access to health care were the most cited pertinent issues among key stakeholder interviewees.

Key stakeholders, focus group participants, and life history interviewees were asked to detail the most important issue(s) for child migrant health based on their experience and knowledge. Eleven pertinent issues were described out of 14 key stakeholder interviews, and four individuals described more than one pertinent issue with a total of 18 responses. Five interviewees cited mental health as the most important issue needing greater attention; five interviewees cited access to healthcare; and two interviewees cited legalizing migrants' stay and the need for greater legal assistance. All other issues had one interviewee cite it as the most pertinent issue and they include the structure of competency training; nutrition; dental/oral hygiene; medical assessments; universal health care coverage; social protection services; primary caregiver stability; and housing. Focus group and life history participants described three key issues: conditions of children in detention, ankle monitors, and the rights of migrants.

4.1.1 Mental health

The burden of mental health issues and trauma is largely based on the children's journey from Central America and their stay in the detention centers. One interviewee said that some children "basically walked from Central America. They are exhausted, they need rest, and they need mental health services." After an exhausting and traumatic journey, the children are placed in detention centers, which are also traumatic experiences. Another interviewee said that "children need to feel nurtured, connected and compassion." The detention centers were described as "practically prisons" with over-regulated stays, which create stress and lead to a deterioration of health. Examples of mental health issues and trauma include depression, anxiety, post-traumatic stress disorder, domestic abuse, gang recruitment and sexual assault. One interviewee said, "We see cases of mental health issues very frequently while preparing children in the shelter to go to the court. One of the children suffered from trauma and could not speak. Other children developed mental health issues as a response to extreme abuse and they cannot even remember the trauma."

Conditions of children in detention, ankle monitors, and the rights of migrants were the main concerns among immigrant families living in the U.S.

4.1.2 Access to health care

Stakeholder interviewees indicated that access to healthcare is a pertinent issue, saying that "these children [child migrants] cannot access healthcare services because they are labeled as migrants." By access to care, an interviewee said that it is more than transportation or an insurance card, but access to health care for migrant children and their families includes that they know where to go to receive health services, what to do if they do not have insurance, and the availability of language services in the health facilities. Additionally, undocumented migrants cannot access Medicare coverage. Another interviewee cited school health services as sometimes available, but not yet optimal. Although school-based health services are recommended by the State, not all public schools have the financial means to employ nurses. Some schools do not even have a social worker to make referrals. The last reason cited for a lack of access to healthcare was fear. Fear is a barrier to health care services for undocumented migrants – fear of deportation or fear of being labeled as 'undocumented.' Two policy-makers indicated that health status and access to healthcare services are a major concern for migrant populations in general, including children. Access to care is a pertinent issue because unaccompanied children are not eligible for healthcare programs and they do not have the means to pay for their health care.

4.1.3 Children in detention

In the first focus group, the conditions of children in detention centers was a point of key concern. Even in remembering the conditions of detention, for their children, a mother cried as she recalled her experience of being detained with her two young children. She noted that there was a lack of privacy, lack of adequate and appropriate food, lack of warm blankets, and a lack of medical care in detention facilities.

4.1.4 Ankle monitors

In one life story interview, a Salvadoran mother of two young children and who is pregnant with a third noted that the experience of living with an ankle monitor was the most significant issue for migrant health. She noted that she cannot travel over 60 miles from her home. She does not have a work permit and is not able to work. In addition, she notes that the ankle monitor causes stigma as people in public look at her as if she were a criminal. In addition, the monitor is very uncomfortable and vibrates or gives shocks at times. At the time of the interview, she was in the early stages of pregnancy and was seeking a doctor's order to have the monitor removed as quickly as possible. She noted that she knew another woman in the same situation.

4.1.5 Migration

One life history participant stated that the most important issue was the specifically entire process of migration, "what one suffers in the journey and here [in the US]" She specifically named the suffering in the *hielera* (Customs and Border Patrol Holding cells, called iceboxes in Spanish because of cold temperatures) including the cold and sleeping on the floor with her young children.

4.1.6 Rights to healthcare, education, and clinics

In the first focus group and also in the life story interviews, participants mentioned the importance of rights to healthcare, to education and to clinics. When asked "what was the most important issue for child migrant health," a woman in focus group one stated, "We have rights, right to health, to education. . . .We should be treated not as migrants, but as people." In one life story interview, a participant noted that the most important issue was not being taken into account, or seen as invisible, as a migrant by many groups of people, "starting on top and continuing all the way down."

4.2 Country of origin

Interview questions for country of origin addressed two key topics: reasons for migration from these regions and health conditions in sending countries.

4.2.1 Reasons for migration

The reasons for migration described in interviews with stakeholders and migrants themselves focused on violence and physical and economic security. Violence in the sending countries included violence from gangs, impunity for crimes and general insecurity. All of the focus groups and migrant life histories named violence as a significant factor in their country. One woman from El Salvador who came to the US with her two young children noted: “In one day there were five deaths near my home. This happened just two weeks before I left.” A healthcare professional noted that many migrants had witnessed violence and also received direct threats: “People would witness a family member being killed and they are told that they will follow.” Interviewees also noted the lack of jobs and especially lack of jobs with sufficient pay to support a family as a reason for migration. In addition, interviewees tied the economic insecurity to the violence in sending countries. In particular, for El Salvador and Honduras, migrants interviewed reported that people had to pay a “tax” (bribe or extortion) to gangs. One Honduran reported that those who do not support the ruling party will not be able to get jobs.

Several interviewees noted the connections between US political and economic policies and circumstances in the sending countries. These connections include free trade policies, such as the North American Free Trade Agreement, which was noted as contributing to poverty in Mexico; the deportation of gang members from US prisons to Central America; the US weapons market in Latin American; and the extractive industries (e.g., mining and agriculture) which can displace rural producers.

These reasons for migration were closely tied to the specific reasons for child migration from these regions. Stakeholders reported that families send their children to the U.S to protect them from being victims of violence, sexual harassment or rape, or from being recruited by gang members. Migrant families noted that they brought their children to escape the violence and to keep children protected from gangs. They also noted the risk of sexual assault for young girls. Families also sought a better life for their children and economic improvement for families; in some cases, they escaped domestic violence or extreme poverty. Children also migrated to join with family members who were living in the US. In addition, some migrated in search of medical care for children: one key informant referenced three cases of families who came to the US in search of care for children with disabilities. The families could not find care in their sending countries. A woman from El Salvador with a child with diabetes migrated, in part, so that her child could seek medical care and attend school.

4.2.2 Health in sending countries

A key theme in the interviews was the inequitable access to healthcare in Mexico and Central America. While interviewees (both key informants and migrants) noted that public healthcare is available, especially from clinics in Mexico and Central America, they noted inequities in distribution. For Mexico, the discrimination against indigenous peoples as well as the lack of clinics in rural regions was referenced as leading to poorer care. For Central America, interviewees noted that medicine may not be available in the clinics and that people may have to pay for it themselves; specialized care is often available in urban areas, forcing those in countryside to invest money in travel. However, several interviewees noted that many of the children were healthy until they were detained in the US or before they made the journey toward the US.

Regarding physical health in sending countries, key informants and migrant families stated that lack of sufficient food was an important issue. In Guatemala, children may work in the fields to help families and access sufficient food supplies, as reported by one nongovernmental organization (NGO) key informant who witnessed children with scars from machetes. Regarding mental health, interviewees noted that observing violence caused trauma and stress for children and adults. One interviewee (NGO) observed that children carry trauma from hearing about or witnessing killings themselves in their sending countries. To quote a migrant mother, “Psychologically it affects you; you see, but you cannot say anything. You cannot say anything because of fear. You don’t know if your own neighbor will betray you.”

4.3 Immigration journey

The interviews described harsh and dangerous conditions on their journey to the US and through south Texas with limited access to healthcare. This can be a two- to four-week trip through Mexico. Key issues reported include:

- Sexual assault, including rape
- Kidnappings and extortion: some families being held at gunpoint, with captors demanding money for release
- Lack of access to healthcare in journey through Mexico: one NGO reported that healthcare is available (clinics run by Mexican government, Red Cross, and others), but most migrants are not aware that these exist
- Crossing the Rio Grande River at US-Mexico border is dangerous and deadly
- Risk of human trafficking: one story of two young women who were "sold" into prostitution
- Mental Health: Women report trauma from journey. One woman reported finding a cadaver in Texas in a state of significant decomposition; one saw people disappear in the river, perhaps drown on her journey through Mexico
- One interviewee was injured (paraplegic) from a car accident; the car was crossing south Texas and the driver (guide) panicked when being chased by police

4.4 Apprehension and detainment

Interviews address the issues of health and access to healthcare in the process of apprehension and detainment. This included apprehension at or near the US-Mexico border, detention in US Custom and Border Patrol (CBP) holding cells, and detention in the Karnes and Dilley Family Residential Units. In addition to the interviews on this issue, two members of the research team together with a member of the advisory board conducted a site visit to the Karnes Unit in order to learn more about health and access to healthcare for the families in detention.
Stakeholders and migrant families raised significant concerns about conditions at the CBP holding cells. These sites were referred to as "hieleras" (iceboxes) by the migrants and their families because of their cold temperature. Some the key concerns about the hieleras include:

- Food: Interviewees noted that the food was insufficient, unfamiliar and of poor quality. Some noted that children refused to eat the food because of its poor quality; a stakeholder noted that children lost weight during this detention.
- Medical Attention: Focus group and life history interviews noted a lack of medical attention overall in the hieleras. A healthcare provider noted that people are in close contact for a long period of time, increasing health risks. A stakeholder noted that upper respiratory infections are common in those leaving the hieleras due to the cold temperature at these centers. Another stakeholder noted that the children are generally healthy until they are detained.
- Privacy: In both focus groups, women mentioned the lack of privacy in the hielera and that this was not appropriate for children. Some reported sleeping in large groups in and around the bathroom. Guards are reported to constantly patrol the facility.
- Beds: Interviewees noted the lack of beds in the hieleras, which meant that people had to sleep on the floor.
- Insecurity: Stakeholders and other interviewees noted a general sense of insecurity and uncertainty as people did not know what would happen next. One woman in a focus group noted that guards make people afraid, telling them they will be deported.
- Disorientation: One woman noted that there is no clock in the hielera and one is generally disoriented, not knowing if it is day or night.
- Trauma: Stakeholders and focus groups noted the time in the hielera is particularly traumatic; detainees do not know what is next.

The stakeholders and migrants also addressed the conditions at the family residential units, Karnes and Dilley. Some concerns about these units include:

- Environment: Stakeholders noted that the Family Residential Units were prisonlike, with families regularly monitored. One stakeholder noted that the units were not appropriate for infants, "Mothers with babies who experience problem in their milk production were told to drink a lot of water or give their babies juice – they were not really set up for babies."

- Medical Care: Stakeholders reported that the initial medical screening at family units was insufficient. Inappropriate healthcare services were reported for children with disabilities. Stakeholders reported that some of their clients had long waits to see healthcare practitioners in detention. Sometimes children are referred to local hospitals for emergency or specialized care services.
- Mental Health: Stakeholders reported insufficient mental health care practitioners. Two stakeholders reported attempted suicides within family detention facilities. One stakeholder reported having interviewed mothers with children who showed signs of acute trauma, "hand wringing and crying." A stakeholder noted the increased risk for anxiety, sleep problems, stress, and inability to focus arising from detention.
- Health Records: Some stakeholders had seen health records from these facilities; others said that they had tried repeatedly to get health records but were never able to. A stakeholder noted that the records are insufficiently detailed and may not move with the person released from the facility.

4.5 Living in the community

Interviewees described their experiences of living in the US or the known experiences of migrants living in US communities. Questions centered around general health, mental health, access to healthcare and healthcare services, and laws and migration.

Generally, interviewees described better physical health status once children were released to community settings from detention facilities, with the exception of mental health. Health status varied based on age, gender, and whether the child came to the US accompanied or unaccompanied. Reproductive health issues for females were reported. For accompanied children, better health status was reported because mothers could better elaborate the health status and history of their children.

Mental health was cited in key stakeholder interviews, the two focus groups, and two life history interviews. Fear, depression and stigma were named as key concerns alongside anxiety and PTSD from the experiences of enduring violence at various stages (country of origin, the journey, and detention). One woman noted: "To live in fear is very ugly because I live in fear of what could happen. Now I have two children and living with this fear is terrible everyday. But that is what we have to do. In this country, driving isn't a luxury. We need to drive, it is a necessity. …. I don't like to go out because of what can happen." This woman had been previously deported to her country in Central America and had to return to the US to be with her son and husband. For this reason, she spoke of the "everyday" fear that this could happen again.

The two life history interviewees spoke of the impact of migration on mental health. One young Honduran stated that, "When you are afraid it affects you. It is not only about the physical body. The most important thing is that you don't let it affect your mind, because the mind has lots of impact on the actions one can take. So instead of fear in our mind, one should have great creativity." This migrant is now in a wheelchair as a result of a car accident while crossing south Texas. A Salvadoran woman with an ankle monitor spoke of the stigma she experienced from having the monitor visible. She said one of the hardest things to deal with was, "All the looks that people give you. The people here in [location deleted to protect identity] look at you; they notice the ankle monitor. . . . My children ask why I have this [ankle monitor]."

In the stakeholder interviews, the two focus groups, and in the two life story interviews, participants discussed severe limitations to healthcare services in the United States. They named specific barriers to access to care including:

- Money: Healthcare was described as being expensive, especially if one has no insurance or Medicaid. People noted that you can seek healthcare but will receive a large bill.
- Lack of Resources: Several women in focus group one noted that without resources, one has to take their children to the emergency room to seek out care.
- Disability: One life story participant who is paraplegic, noted having to go to the emergency room for care, and having to wait for 20 hours before he could see a doctor. Stakeholders described a lack of disability services for children in receiving communities: "We generally treat people with disability poorly. Imagine children with disabilities, poor, migrants, and do not speak English!"
- Language: One woman noted that when she was calling a clinic to try to get her child vaccinated for school, she could not find a Spanish speaker. Stakeholder interviewees also described greater language barriers for indigenous migrants.

- Dental Care: Dental Care was described as being particularly expensive in the US with people seeking out alternative forms of care to address this need.
- Legal Status: In both focus groups, the women noted that children born in the US have some access to care through Medicaid. However, those who are not born in the US do not have access to care. Stakeholders also noted more options for children with refugee or asylum status, but even then some people do not know how to community health centers.

In addition, in one life history interview, the participant named the discrimination in the healthcare system, saying that migrants are "ignored" because they are seen as illegal. She noted, "If they know a person is 'illegal' they don't treat you the same as they treat people with money."
Some women in each focus group had children who were born in the United States. They noted that these children had access to healthcare through Medicaid. They also noted access to other services in the US such as schools and Women Infant and Children (they specified milk for children). Some interviewees had a Gold Card (available in Harris County), which allows significant discount for their medical care. One stakeholder observed that one must provide a photo identification to apply for a Gold Card, a requirement that can create a significant barrier for this migrant population.
One life story interviewee noted the connection between legal status and access to healthcare and humane treatment. He told the story of a woman whose husband was very ill with cancer. The wife tried to get a humanitarian visa in order to stay in the US with her husband. The visa was approved by the consul; however, the US denied the visa. The participant commented on this, noting, "They reject the person."

4.6 Suggestions for action

These suggested action items are based on recommendations from each focus group and life story interview. Participants were asked what is needed to improve the health of migrants and this led to reflections on issues of human rights and migration broadly. We include their suggestions as a guide for future policy recommendations.

4.6.1 Health and human rights

One life story participant stated that the right to health for all should be recognized. He stated, when asked what is needed to improve migrant health, "that every human being has the right to health, this is the most important, that it doesn't matter what kind of 'raza' [race] each person is. That you have to work to better each person." A woman in focus group one stated, "The government must recognize migrants as being key to this country."

The first focus group also noted that the key issue to change was a recognition of rights. Women spoke of the need for health care for the children but also for their parents. They noted the need for health insurance for parents and their children, something similar to CHIP or Medicaid where parents would pay part of the costs.

4.6.2 Migration

One life story participant noted that migration was a key issue and that there should be support for legal status. He stated, "They should see the situation of each person and that every person has rights. They should learn the reasons that people came here."

- In a focus group, women mentioned the need for work permits to be able to support their families.
- Women in focus group noted the need for an identification and driver's license [to not have fear of going out in public]
- Women in focus group one also noted that "Texas is against migrants. They are against our children. It is the state of Texas that put in place a legal demand [to stop Deferred Action for Parent Accountability] and this goes against migrants. They are against us. They are against our children too."
- In the second focus group, women spoke of the importance of having papers to be in the US. They could get health insurance with papers in the US.

5 POLICY CHANGE STRATEGIES TO IMPROVE ACCESS FOR CHILD MIGRANTS IN TEXAS

Chapter 4 identifies issues pertinent to child migrant health from the perspective of families, CBOs, and other experts knowledgeable of the health risks and healthcare access of child migrants. These views were considered when identifying ways to reduce health risks and/or improve access to care for this group.

This chapter presents two policy recommendations that arise from the research and mechanisms in which those recommendations can be operationalized as state policy. One of these is targeted as a Core Policy for implementation within three to five years; however, we present a strategy that involves placing it on policy-makers' agenda during the current legislative session. We conclude with a discussion of future collaborative efforts to address this complex issue.

5.1 Two recommendations to improve child migrant health

Based on the analysis, some members of the research team identified two recommendations that would improve the health of child migrants through state policy. First, we recommend ending family detention. Our literature review, site visit, and interviews indicate that family detention is harmful to children, unnecessary, and expensive. From a human rights perspective, it goes against the Geneva Declaration on the Rights of the Child. From a public health perspective, detention is traumatizing and an inappropriate place for sheltering children. While unaccompanied child migrants are sent to HHS shelters consistent with the Flores Settlement Agreement, accompanied children are sent to family detention—despite the Flores v Lynch decision that the Flores Settlement Agreement applies to children independent of whether they are accompanied.

This recommendation is consistent with the DHS's own Advisory Committee on Residential Centers. Their report states the following:

> "Recommendation 1-1: DHS's immigration enforcement practices should operationalize the presumption that detention is generally neither appropriate nor necessary for families – and that detention or the separation of families for purposes of immigration enforcement or management, or detention is never in the best interest of children. DHS should discontinue the general use of family detention, reserving it for rare cases when necessary following an individualized assessment of the need to detain because of danger or flight risk that cannot be mitigated by conditions of release."[59]

Although this might be considered a policy issue for the federal government, there is precedent for state action, which we discuss in Section 5.2.

The second recommendation addresses barriers to healthcare access, particularly to mental health services, that child migrants experience in the US. Interviewees identified access to healthcare, especially mental health services, as one of the most pertinent issues for child refugees. Mental health services should include both screening and treatment for PTSD. Just as important, culturally and linguistically appropriate healthcare is needed through the duration of the child migrant's journey in the US independent of whether the child is accompanied.

In considering recommendations to address gaps in healthcare access, some members of the research team were struck by the similarities between unaccompanied child migrants and children living in foster care. Whereas the first group is released to a sponsor, the latter is released to a foster family. Both often experience significant trauma and live in the community with someone other than their parent. Children in foster care receive a screening for PTSD and have access to behavioral health services through a Medicaid managed care organization (MCO). That Medicaid MCO (Superior) has a presence in every county in Texas, provides a full range of services, and has providers with experience in the kinds of mental health issues associated with trauma. In contrast, unaccompanied child migrants released to sponsors in the community are Medicaid non-qualified. Until a Justice Department immigration court makes a ruling about their immigration status, they are ineligible for Medicaid even if they meet income and other requirements. Thus, child

migrants living in the community struggle to find culturally and linguistically appropriate care, especially for mental health.[v]

Given the contrasting treatment across two analogous groups, unaccompanied child migrants released to a sponsor and children in foster care, we recommend that both accompanied and unaccompanied child migrants released to a sponsor in the community should receive the same healthcare services that children in foster care receive. This implies expanding Medicaid to cover services for child migrants that currently lack immigration status—a decision that several states, by expanding medical services to undocumented children with low income, have already taken.

Below, we discuss two policy levers state policy-makers can use to implement these two recommendations. Based on our understanding of the policy environment, we identify one core policy that is potentially implementable within three to five years.

5.2 State policy levers to address child migrant health

Although immigration policy is a federal prerogative, there are two key mechanisms in which states can impact child migrant health: (1) states issue licenses for the facilities in which child migrants are housed, and (2) states can develop and fund services geared to this population, even if they lack legal immigration status. We discuss each of these with examples from other states and some of the complications associated with their implementation in Texas.

5.2.1 State licensure of family detention facilities

Through their power of licensure, state governments have a mechanism for determining the availability and quality of the facilities in which child migrants are sheltered. This includes both HHS facilities sheltering unaccompanied child migrants as well as DHS facilities housing child migrants in family units. There are three facilities in the country that house children in "family detention." Two of these are in Texas; the third and smallest is in Pennsylvania. Despite similar outcries over the conditions in all three "family detention" facilities, Pennsylvania's response provides one model for improving child migrant health: end the practice of family detention by revoking the facility's license. By ending the licensure of the facility, ICE will have an incentive to offer community alternatives to family detention, and child migrants in family units will no longer be exposed to the traumatizing effects of a prison environment.

In January 2016, the Pennsylvania Department of Human Services revoked the license of the Berks County Family Detention Facility.[vi] This action was in response to an outcry over the facility's poor living conditions, a hunger strike by mothers residing in the facility, and strong support among elected officials to close the facility. Despite that, the facility has remained open without a license for all of 2016. During that time, the county appealed the state government's revocation as advocates and policy-makers appealed to federal officials to end family detention. For example, Senator Bob Casey (D, PA) sent a letter in December to DHS Secretary Jeh Johnson urging him to close the facility and recommending alternatives to detention. The letter cited the well documented "psychological and medical impacts of long-term detention on traumatized women and children…. [including reports of] children as young as six years old … diagnosed with Post-Traumatic Stress Disorder and have expressed thoughts of suicide."

In contrast to Pennsylvania, Texas government accommodated ICE's request to develop regulations enabling the licensure of the Dilley and Karnes sites as a new category of state childcare facilities. Oddly, the Department of Family and Protective Services' (DFPS) licensing rules were not sufficiently stringent to segregate children from unrelated adults. On December 2, 2016 Texas District Court Judge Karin Krump ruled that the DFPS licensing of the Dilley and Karnes facilities was invalid.[58] In issuing the injunction, Judge Krump noted how the new rules "allow, and have allowed,

[v] Foster care for child migrants is not without precedence. Long-term and therapeutic foster care are options ORR considers for some child migrants, particularly resettled refugees. These options depend on strict eligibility requirements and are a very small proportion of all ORR placements. For example, therapeutic foster care is reserved for child migrants with special needs that cannot be provided by a generic sponsor. These programs are funded by ORR, include access to medical care, and are licensed by the state. Most importantly, they are extremely rare for the child migrants that are a focus of this research.

[vi] A fourth facility in New Mexico has been closed.

for situations with children that are dangerous." After the ruling, ICE released 470 residents but still operates the facility without a license.

Like the facility in Pennsylvania, the Texas facilities can still operate without a license while the case is under appeal. The continuing litigation suggests that ending state licensure may be a necessary but not sufficient condition for ending family detention. Ultimately, the Department of Homeland Security must take the lead in ending this practice. However, we recommend that Texas follow's Pennsylvania's lead by revoking licensure. We offer our research as additional evidence for the need to end family detention by withdrawing state licensure of facilities that imprison children. We also expect the Cross-Sectoral Advisory Board on Child Refugee Health, which this research team convenes, to collaborate over the next several years to support ending family detention in Texas.

5.2.2 Providing medical services for undocumented child migrants in the community

Federal law requires the provision of medical care when children are detained and under the supervision of DHS or DHH. Family detention facilities are required to provide medical care as specified in ICE residential standards. ORR pays for and provides for medical and mental health screening and care for unaccompanied child migrants housed in HHS shelters. Our research indicates that these facilities are challenged in their ability to provide culturally and linguistically competent medical care, particularly mental healthcare, to its residents. While new federal regulations, better oversight, and improved funding could address some of these concerns, we leave this issue for future research[vii].

Child migrants in the US face a gap in healthcare access when they are released to a sponsor in the community. The main provision for sponsors is to ensure the child is present at immigration court. Child migrants that receive certain forms of immigration relief (e.g. asylum, U visa or T visa for victims of crime and trafficking respectively) may be eligible for Medicaid and CHIP (if they meet income requirements) and may purchase a health plan in the ACA market place.

Until they receive immigration relief, however, they are considered "non-qualified aliens." As non-qualified aliens, they have limited options for medical care in the community. They may obtain treatment for an emergency medical condition in a hospital emergency room. They may qualify for emergency Medicaid to treat an emergency medical condition (excluding organ transplants) if they meet all other state eligibility requirements. Many seek care at safety net providers, such as a FQHC, where undocumented migrants may receive services on a sliding scale. However, obtaining linguistically and culturally appropriate services at a nearby FQHC, especially for mental health care, may be a challenge[viii].

Some states have decided to treat all children equally and provide health coverage regardless of legal status. In New York, all children under age 19 are potentially eligible for Child Health Plus, a program that provides free or low-cost health insurance for children who do not qualify for Medicaid, regardless of immigration status. Health4AllKids is a new program in California that expands Medicaid eligibility to low-income children regardless of immigration status. The expansion covers preventative, primary care, dental and mental health services. Finally, Illinois' All Kids program covers all children under 19 who meet income requirements regardless of immigration status. Because federal funds may not be used to provide non-emergency healthcare, these programs are financed entirely by the state.

The prospects for Texas to make any new medical services available to immigrants, least of all those lacking legal status, is highly unlikely in the short-term. Texas has some of the most stringent Medicaid eligibility requirements in the nation. It has rejected Medicaid expansion in the face of the highest rate of uninsured in the country, clear evidence of benefits to its citizens, and well-documented costs to tax payers for not expanding.

Nevertheless, we select this as our core policy. There are ethical imperatives and economic benefits to covering child migrants' medical care. Many of these children will achieve legal status, including permanent residency and asylum. Some of them may become eligible for Medicaid, and early detection and treatment of mental health might lead to cost savings for the state. Moreover, evidence suggests that early detection and treatment might also lead to cost savings for state and local government in education, juvenile justice and other human services budgets. (See Chapter 1.)

[vii] The situation is particularly concerning for ICE facilities. For example, a 2016 report by the US Government Accountability Office indicates that ICE does not have a credible system for tracking the provision and quality of medical care or any medical grievances that detainees may file.

[viii] Children of migrant workers may sometimes receive care at Migrant Health Centers. Child migrants may also receive care in school if a school nurse is available or through an ad hoc clinic.

There are many ways to structure the provision of medical care to child migrants. By offering multiple options in the design of these services, policy entrepreneurs can identify the most politically optimal. Moreover, there are opportunities in the current legislative session to elevate the issue and identify future policy champions.

5.2.3 Estimating the cost of expanding Medicaid to child migrants

How much would it cost the state to provide Medicaid to child migrants released to the community? The University of Syracuse provides extensive data on unaccompanied child migrants in its Transactional Records Access Clearinghouse. The Office of Refugee Resettlement details the number of unaccompanied child migrants released to a sponsor by state and fiscal year. Together, these data enable us to estimate: (1) the number of unaccompanied child migrants released to a sponsor, and (2) the number of children who receive a removal order. Removal orders can be used as a proxy for deportation. Subtracting deportations further improves the estimate of person months exposed to the "risk" of Medicaid eligibility in this hypothetical program. Unfortunately, analogous data are not as readily available for child migrants in family detention.

Table 5.1: Estimating the cost of making Medicaid services available to undocumented child migrants released to a sponsor in the community

Statistic	2015	2016
Total Released to Sponsor	4,092	7,271
Percent Removal Order (Assume Deported)	37.3	16.1
Total Deported	1,526	1,171
Total Not Deported	2,556	6,100
Total Cost Deported	$2,443,126	$1,873,170
Total Cost Not Deported	$8,216,332	$19,532,200
Total Cost	**$10,659,458**	**$21,405,370**

Source: Office of Refugee Resettlement, Transaction Records Access Clearinghouse, and Kaiser Family Foundation. Deportations are assumed at a constant rate through the year in equal proportion to removal orders. Medicaid cost estimates are based on an annual per enrollee cost of $3,202 in 2016 dollars for children.

The Kaiser Family Foundation's online tool, State Health Facts, offers an estimate of Medicaid spending on children per enrollee in a given year. Per the online tool, the average Medicaid costs per child enrollee inflated to 2016 dollars is approximately $3,202. We can use that estimate as a proxy for the cost per child enrollee in a Medicaid-type program for child migrants. This enables us to arrive at an estimate of the cost of the program, but only for unaccompanied child migrants. Table 5.1 provides this estimate for the most recent two adjacent years.

The estimates assume that everyone who is released to a sponsor in the community is eligible and becomes immediately enrolled. It also assumes that deportations immediately follow a removal order and that these happen at a constant rate throughout the year. This would suggest these figures are an overestimate. One the one hand, some might argue that the average healthcare cost for the child migrant population is higher than average due to elevated behavioral health costs. On the other hand, others might argue that this population tends to be quite resilient, arguing for lower costs.

Whatever the limitations in the data, the estimates for the two years provide some idea about some of the challenges in financing such a program. First, the numbers are entirely driven not only by variation in migration rates over time, but by ORR and Justice Department immigration court decisions. The total cost estimate doubled across the two years because the number of persons released to sponsors was higher, possibly a result of the greater number of children detained and transferred to HHS in the prior year. In addition, immigration judges issued over half as many removal orders in 2016 compared to the prior year.

One way of controlling for such wild swings would be to control enrollment. Enrollment could be controlled by providing a cap on the total number for which the program would be available. The program could also be available for a limited time, such as a year. The program could be made available only to those considered most likely to remain (e.g., those with a letter from ORR that they screened positive for PTSD or were diagnosed under ORR custody with a serious mental health problem). One final consideration would be to carve out specific services. For example, if mental health is a serious issue, some policy-makers might consider only allowing for primary care and comprehensive behavioral health care with no acute care provision. These parameters would need to be considered more thoroughly before presenting to legislators who might want to champion the policy.

5.3 Developing a strategy for implementing the Core Policy

5.3.1 Identifying opportunities for policy dialogue

In Kingdon's Policy Window model, policy-makers become willing to address an issue on their busy agendas when the three streams of problem, policy, and politics align. Although this report identifies the problem of child migrant health, it has not yet been elevated as a problem issue among state policy-makers – judicial officials notwithstanding. The Texas Legislature is unlikely to make medical services available to child migrants until the politics encourages enough legislators to recognize the issue as a problem sufficient enough to merit tax dollars. Thus, a priority in year one is to elevate the issue of child migrant health. This requires identifying an appropriate platform for enjoining policy-makers in a dialogue about the issue and identifying a policy-maker who will champion the issue at the appropriate time.[60]

With the assistance of the UTMB Office of Health Policy and Legislative Affairs, we identified several bills in the current and 84th Legislative Session related to the core policy. Authorship on these bills was considered a proxy for potential openness to address child migrant health. For each bill, we assessed on a five-point scale (very high, somewhat high, moderate, somewhat low, very low) its potential as a platform for elevating the issue of child migrant health and the need for healthcare when released into the community. We considered whether the author was currently a champion of health or immigrant-related issues, the potential value to the author of incorporating new language related to child migrant health and medical care, and the overall politics around the issue (see Table 5.2). In the case of SB11, HB997 and HB3934, we considered the prospect for a simple rider that created a new program, however limited, for child migrants released to a sponsor in the community.

We assessed four bills. Two of them were introduced this legislative session. The other two were introduced in the prior legislative session with no further action but potentially could be reintroduced this legislative session. The first bill involves the reform of the foster care system. We initially considered this bill given our understanding of the similarities between children in foster care and child migrants living with a sponsor. However, it may be difficult to convince any of the authors of this bill that child migrant health is anywhere near as important as the many troubling issues surrounding the Texas foster care system. For example, the need to finance the hiring and training of new case managers is bound to be an issue which will be only complicated by expanding costly services to a new group of children. Thus, we considered the potential value for this bill as "very low" as a mechanism for advancing the core policy as an issue.[ix]

We ranked both bills introduced in the 84th legislative as "somewhat low" in potential—at least for this year. Although they both deal with Medicaid eligibility, including qualified aliens in one case, we do not think Medicaid will be dealt with in this session at all. How Texas addresses Medicaid will depend on how the 115th Congress deals with the Affordable Care Act. The Health and Human Services Commission has submitted a request to the Center for Medicaid and Medicare Services for an additional 21 months of level funding for the 1115 waiver program. Depending on what happens with ACA, there might be an opportunity to include the Core Policy in the next request, either as expansion of Medicaid through a block grant or as a new Delivery System Reform Incentive Payment (DSRIP) project.

If it passes, Rep. Donna Howard's (D. 48) bill to establish a task force on asylum-seeking children has the greatest potential for elevating the issue of child migrant health. The bill focuses exclusively on Central American children fleeing violence and seeking asylum in the US. By defining them as those that were housed by ICE or ORR, the bill covers both accompanied and unaccompanied children—this study's target population. The task force is charged with studying the humanitarian and fiscal impacts of asylum-seeking children on education and the health and human services sectors, and producing a report about the status of asylum-seeking children. This is an effort that we can support and potentially contribute to.

5.3.2 Action steps for implementing the core policy

Given its potential, a key first step in implementing the core policy will be to meet with Rep. Howard or her staff as early in the current session as possible. The meeting would discuss the research findings and consider ways of improving the outcomes of the task force. The bill specifies a taskforce comprised of eight members appointed by the Texas

[ix] Our community partners expressed discomfort with any legislation involving Child Protective Services (CPS), citing concerns that CPS officials might report sponsors, who may themselves be undocumented, to immigration officials.

Comptroller. However, the task force could benefit from expertise on trauma-informed care. In addition, the task force could benefit from being more explicit about mental health in its report. If HB 278 reaches the floor with a successful vote, the task force becomes an avenue through which the research can elevate the issue to all state policy-makers.

The second step would be to meet with other policy champions in the current legislative session to discuss the team's findings, the core policy, and the value of a task force. We currently have a list of 10 potential champions, half from the Texas Senate and half from the Texas House. They include a mix of members from key committees and backgrounds. We would hold these meetings throughout the current legislative session. Concurrent with these meetings, we would disseminate this report and other research products (e.g., a one-pager and executive summary) to the advisory board and other potential partners in this effort.

These dialogues with policy-makers is only one component of a much larger effort to elevate the problem of child migrant health and their need for physical and mental health services. In addition to disseminating this report and other research products (e.g., plain language summary and one-pager) widely across the state, the team will convene policy dialogues with its own advisory board and with key state agencies, including the Office of Immigration and Refugee Affairs and the Governor's Advisory Committee on Immigration and Refugees.

We will also convene meetings with the staff of the Health and Human Services Commission, which will be tasked with (1) developing a new 1115 waiver after the current renewal expires, and (2) potentially negotiating with the Centers for Medicare and Medicaid Services a plan for financing Medicaid through a block grant. Both are opportunities to incorporate service provision to child migrants. We anticipate these activities will be ongoing through the legislative session in 2019. By 2020, the year of the next presidential election, there is potential that the politics will align with our efforts at policy development.

Table 5.2: Texas bills' potential for supporting the core policy goal

Bill/Authors	Title	Potential
INTRODUCED IN 85TH LEGISLATIVE SESSION		
SB 11/ Schwertner, Nelson, Uresti	An Act relating to the administration of services provided by the Department of Family and Protective Services, including foster care, child protective, and prevention and early intervention services.	**Very Low**. Though unaccompanied child migrants are similar in many ways to children in foster care, the number of other comprehensive issues involving foster care reform makes addressing trauma in child migrants a very low priority for policy-makers interested in foster care. The current budget makes expanding Medicaid to cover child migrants, even for a limited time or limited services, highly unlikely.
HB 278/ Howard	An Act relating to the establishment of the task force on asylum-seeking children.	**Moderate**. Sponsor may be open to expanding membership of task force to include expertise in trauma informed care for asylee-seekers. Potential to advance core policy goal as recommendation for the task force to consider. Prospects for passage unclear.
INTRODUCED IN 84TH LEGISLATURE, POTENTIALLY REINTRODUCED IN 85th		
HB 997/ Collier	An Act relating to expanding eligibility for medical assistance to certain persons under the federal Patient Protection and Affordable Care Act and ensuring the provision of quality care under and the effectiveness of the medical assistance program.	**Somewhat Low**. Medicaid is unlikely to be discussed until the 86th Legislature pending decisions of 115th US Congress on ACA.
HB 3934/ Blanco	An Act relating to Medicaid eligibility for certain residents.	**Somewhat Low**. Medicaid is unlikely to be discussed until the 86th Legislature pending decisions of 115th US Congress on ACA. Bill focuses on qualified aliens, but potential to consider extending to certain categories of non-qualified. Potential to include language requiring screening qualified alien minors for PTSD. Suggest that qualified aliens be covered by Superior Health Plan.

5.4 Long-term strategy

This report only discusses one potential strategy for addressing the health of child migrants, namely, providing medical services during the period while in the community before receiving immigration relief that might otherwise make them eligible for more comprehensive medical and mental health services. The recommended strategy includes engaging with legislators in 2017 with the expectation that other opportunities for placing a policy on the legislative agenda would arrive again in 2019 and 2020.

The project team, however, will continue engaging its cross-sector advisory board on child refugee health. During 2017 we will engage this group through a series of policy dialogues to hone strategy while considering additional policy recommendations. This will be a core activity to mobilize action to address the health of child migrants. In addition, the UTMB Center to Eliminate Health Disparities, in cooperation with UTMB's new Institute for Global Health Initiatives, will begin convening an annual Migrant Health Conference in collaboration with the Pan American Health Organization. Legislators engaged during the 85th Legislative Session will be invited to participate. This could enhance attention and build awareness of the importance of child migrant health across the state.

6 REFERENCES

1. Washington Office on Latin America (WOLA). *Five Facts about Migration from Central America's Northern Triangle*. 2016 [cited 2016 January 15]; Available from: https://www.wola.org/analysis/five-facts-about-migration-from-central-americas-northern-triangle/.
2. United Nations Office on Drugs and Crime (UNODC), *Global Report on Trafficking in Persons*. 2016, United Nations Office on Drugs and Crime (UNODC): Vienna.
3. United Nations Children's Fund (UNICEF), *Declaration of the Rights of the Child (Proclaimed by General Assembly Resolution 1386(XIV) of 20 November 1959)*. 1959.
4. Pan American Health Organization (PAHO). *Health of Migrants (Policy Dcument and Resolution) - adopted during the 55th Directing Council Session*. 2016 [cited 2017 January 24]; Available from: http://www.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=35873&Itemid=270&lang=en
5. Kandel, W., *Unaccompanied Alien Children: An Overview - Prepared for Members and Committees of Congress*. 2016, Congressional Research Service.
6. US Citizenship and Immigration Services. *Refugees*. 2017 [cited 2017 January 24]; Available from: https://www.uscis.gov/humanitarian/refugees-asylum/refugees.
7. US Citizenship and Immigration Services. *Asylee*. 2017 [cited 2017 January 24]; Available from: https://www.uscis.gov/tools/glossary/asylee.
8. Pew Research Center (Hispanic Trends). *Overall Number of U.S. Unauthorized Immigrants Holds Steady Since 2009: Decline in share from Mexico mostly offset by growth from Asia, Central America and sub-Saharan Africa*. 2016 [cited 2017 January 24]; Available from: http://www.pewhispanic.org/2016/09/20/overall-number-of-u-s-unauthorized-immigrants-holds-steady-since-2009/.
9. Felitti, V.J., et al., *Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study.* Am J Prev Med. 1998 May, 14(4):245-58, 1998.
10. Campbell, J.A., Walker, R. J. and Egede, L. E., *Associations Between Adverse Childhood Experiences, High-Risk Behaviors, and Morbidity in Adulthood.* Am J Prev Med. 2016 Mar., 50(3)344-52, 2016.
11. Guinosso, S.A., Johnson, S. B., Riley, A. W., *Multiple adverse experiences and child cognitive development.* Pediatric Research, 2016(79):220-226, 2016.
12. Miller, G.E., Chen, E. and Parker, K. J., *Psychological Stress in Childhood and Susceptibility to The Chronic Diseases of Aging: Moving Toward a Model of Behavioral and Biological Mechanisms.* Psychol Bull. 2011 Nov., 137(6):959-97, 2011.
13. Turner, R.J., Thomas, C. S. and Brown, T. H., *Childhood Adversity and Adult Health: Evaluating Intervening Mechanisms.* Soc Sci Med. 2016 May;156:114-24, 2016.
14. Allwood, M.A., Bell D. J. and Husain, S. , *Children's Trauma and Adjustment Reactions to Violent and Nonviolent War Experiences.* Journal of the American Academy of Child and Adolescent Psychiatry 41(4):450-7, 2002.
15. Desai, A., and Stevenson, L., *Re-hospitalization for Heart Failure: Predict or Prevent? .* Circulation, 2012-126 (Special Report):501-506, 2012.
16. Fazel, M., Wheeler, J., and Danesh, J., *Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review.* The Lancet. 2005 Apr 9-15;365(9467):1309-14., 2005.

17. Afifi, T.O., MacMillan, H. L., Boyle, M., Tamara, T., Cheung, K., and Sareen, J., *Child abuse and mental disorders in Canada.* CMAJ. 2014 Jun 10; 186(9): E324–E332. , 2014.
18. Bonomi, A.E., Anderson, M. L., Rivara, F. P., Cannon, E. A., Fishman, P. A., David, C., Reid, R. J., and Thompson, R. S., *Health Care Utilization and Costs Associated with Childhood Abuse.* J Gen Intern Med. 2008 Mar; 23(3): 294–299. , 2008.
19. Petrou, S., Johnson, S., Wolke, D., Hollis, C., Kochhar, P., and Marlow, N. , *Economic Costs and Preference-Based Health-Related Quality of Life Outcomes Associated with Childhood Psychiatric Disorders.* The British Journal of Psychiatry Oct 2010, 197 (5) 395-404, 2010.
20. Perreira, K.M., and Ornelas, I. , *Painful Passages: Traumatic Experiences and Post-Traumatic Stress among Immigrant Latino Adolescents and their Primary Caregivers.* Int Migr Rev. 2013 Dec; 47(4): 10.1111/imre.12050.
21. Collier, L., *Helping immigrant children heal.* American Psychological Association 2015, Vol 46, No. 3: p 58, 2015.
22. Corlett, D., Mitchell. G., Van Hove, J., Bowring. L., and Wright, K., *Captured Children*. 2012, Melbourne: International Detention Coalition.
23. Holman, B., and Ziedenberg, J., *The Dangers of Detention: The Impact of Incarcerating Youth in Detention and Other Secure Facilities*. 2016, Justice Policy Institute.
24. End Immigration Detention of Children. *The Impact.* 2017; Available from: http://endchilddetention.org/impact/.
25. Regugees Services of Texas. *Houston*. 2017 [cited 2017 January 26]; Available from: http://www.rstx.org/houston.html.
26. Office of Refugee Resettlement. *Unaccompanied Children Released to Sponsors by State*. 2017; Available from: https://www.acf.hhs.gov/orr/programs/ucs/state-by-state-uc-placed-sponsors.
27. International Organization of Migration, *World Migration Report 2015 - Migrants and Cities: New Partnerships to Manage Mobility*. 2015: International Organization for Migration.
28. Le Mesurier, S. *The Phenomenon of Migration: Its Significance or Meaning in Human Societies Throughout History*. 2012; Available from: http://www.ifrc.org/en/news-and-media/opinions-and-positions/speeches/2012/test/.
29. International Organization of Migration. *2015 Global Migration Trends: Factseet*. 2015; Available from: https://publications.iom.int/system/files/global_migration_trends_2015_factsheet.pdf.
30. United Nations Development Programme, *Human Development Report 2009 Overcoming barriers: Human mobility and development'*. 2009.
31. United Nations High Commissioner for Refugees (UNHCR), *Global Trends: Frced Displacement in 2015*. 2015.
32. International Labour Organization (ILO), *ILO Global Estimates on Migrant Workers: Results and Methodology - Special Focus on Migrant Domestic Workers*.
33. United Nations, *World Popualtion Prospects: Key Findings and Tables*. 2015.
34. Organization of American States, *International Migration in the Americas: Third Report of the Continuous Reporting System on International Migration in the Americas (SICREMI)*. 2015.
35. Gonzalez-Barrera, A., *Apprehensions of Mexican Migrants at U.S. Borders Reach Near-Historic Low*. 2016, Pew Research Center.
36. Gonzalez-Barrera, A. *More Mexicans Leaving Than Coming to the U.S.* 2015 [cited 2017 January 27]; Available from: http://www.pewhispanic.org/2015/11/19/more-mexicans-leaving-than-coming-to-the-u-s/.
37. Dimock, M. *How America Changed During Barack Obama's Presidency*. 2017 [cited 2017 January 27]; Available from: http://www.pewresearch.org/2017/01/10/how-america-changed-during-barack-obamas-presidency/.
38. US Customs and Border Protection. *Southwest Border Unaccompanied Alien Children*. 2014; Available from: http://www.cbp.gov/newsroom/stats/southwest-borderunaccompanied-children-2014.
39. Carrasco, P., Ángel, M., Cerda-García, A., and Ledón-Pereyra, A. *Mirar Las Fronteras Desde el Sur: Salud y migración en la frontera México-Centroamérica*. 2016.
40. Ibarra, A.B., and Byanyima, W. *Latin America is the world's most unequal region. Here's how to fix it*. 2016 [cited 2017 January 15]; Available from: https://www.weforum.org/agenda/2016/01/inequality-is-getting-worse-in-latin-america-here-s-how-to-fix-it/.
41. Lusting, N. *Most Uneqaul on Earth*. Finance and Development 2015 [cited 2016 January 15]; Available from: http://www.imf.org/external/pubs/ft/fandd/2015/09/pdf/lustig.pdf.
42. The Economist, *Inequality in Latin America: A Stubborn Curse*, in *The Economist*. 2003.
43. Fajnzylber, P., D. Lederman, and N. Loayza, *Inequality and Violent Crime.* Journal of Law and Economics, 2000. XLV (April 2002): p. 1-40.
44. International Crisis Group, *Easy Prey: Criminal Violence and Central American Migration*. 2016.
45. The Economist, *Tariffs and Tortillas.* 2008.
46. United Nations High Commissioner for Refugees (UNHCR), *Women on the Run: First Hand Accounts of Refugee Fleeing.* 2015.
47. United Nations Office on Drugs and Crime (UNODC), *Transnational Organized Crime in Central America and the Caribbean: a Threat Assessment*. 2012.
48. Renwick, D. *Central America's Violent Northern Triangle*. 2016 [cited 2017 January 27]; Available from: http://www.cfr.org/transnational-crime/central-americas-violent-northern-triangle/p37286.

49. Death Penalty Information Center. *Murder Rates Nationally and By State*. 2017 [cited 2017 January 15]; Available from: http://www.deathpenaltyinfo.org/murder-rates-nationally-and-state#MRreg.
50. United Nations Children's Fund (UNICEF), *Hidden in Plain Sight: A Statistical Analysis of Violence against Childrren*. 2014.
51. Honduras Mas Noticias, *Imperios de la Extorsion estan en Honduras y El Salvador*, in *Honduras Mas Noticias*. 2015.
52. Central America Data.com. *70 percent of MiyPEs in El Salvador Suffer From Extortion*. 2013; Available from: http://en.centralamericadata.com/en/article/home/70_of_MiyPEs_in_El_Salvador_Suffer_From_Extortion.
53. Wirtz, A., Alvarez, C., Guedes, A., Brumana, L., Modvar, C., and Glass, N., *Violence against children in Latin America and Caribbean countries: A Comprehensive Review of National Health Sector Efforts in Prevention and Response.* BMC Public Health, 2016. (2016) 16:1006
54. Bustamante, J., *Promotion and Protection of All Human Rights, Civil, Political, Economic, Social And Cultural Rights, Including the Right to Development: Report of the Special Rapporteur on the Human Rights of Migrants.* 2008.
55. Human Rights Watch. *Explorte United States: Immigration*. 2016; Available from: https://www.hrw.org/united-states/immigration.
56. American Civil Liberties Union. *Analysis of Immigration Detention Policies: Support Fair Detention Policies*. 2017; Available from: https://www.aclu.org/other/analysis-immigration-detention-policies.
57. Human Rights First. *The Flores Settlement: A Brief History and Next Steps*. 2016 [cited 2017 January 27]; Available from: http://www.humanrightsfirst.org/resource/flores-settlement-brief-history-and-next-steps.
58. The District Court of Travis County - Texas, *Final Judgment-Grassroots v. TDFPS, eta/. and CCA and The Geo Group* T. The District Court of Travis County, Editor. 2016.
59. DHS Advisory Committee, *Report of the DHS Advisory Committee on Family Residential Centers*. 2016.
60. Kingdon, J.W., *Agendas, alternatives, and public policies. Vol. 45. Boston: Little, Brown, 1984.* Vol. 45. Boston: Little, Brown, 1984, 1984.

7 ABOUT THE AUTHORS

Kenneth D. Smith, PhD, Director of the UTMB Center to Eliminate Health Disparities at UTMB, is a health economist, public health practitioner and health equity advocate. His research focuses on improving health equity through policy, systems and environmental change. As the Principal Investigator for the Child Refugee Health Project, he was involved in all aspects of the project, particularly development of the conceptual framework, the sample frame, conducting interviews, developing policy recommendations, and drafting the report. He serves as the Co-Chair for the Cross-Sector Advisory Panel on Child Refugee Health.

Hani Serag, MD, a Health System Research Fellow at the UTMB Center to Eliminate Health Disparities, has research interests in the socioeconomic determinants of health and health-related governance structure and decision-making processes. For this project, he contributed to the development of the study design, sampling, data collection protocols and data collection tools. Dr. Serag conducted executive interviews jointly with other investigators and contributed significantly to data analysis including open coding, tabulation of results and report writing.

Shannon Guillot-Wright, MA is a Community Health Research Fellow at the UTMB Center to Eliminate Health Disparities. She is also a PhD candidate at the UTMB Institute for Medical Humanities. Her research interests include labor conditions as a sociopolitical determinant of health. In this project, she helped develop the sample frame, conducted key stakeholder interviews, participated in a detention center site visit, and assisted with the transcription, coding, and analysis of data results. Additionally, she contributed to study design, ethical considerations, and report writing.

Christopher S. Greeley, MD, MS is a Professor of Pediatrics at Baylor College of Medicine and the Chief of Section of Public Health Pediatrics at Texas Children's Hospital. Dr. Greeley evaluates children who are suspected victims of child abuse and neglect and currently is developing collaborative, community-based strategies to address childhood and family adversities. He has served as a pediatric and public health consultant and helped frame recommendations for policy development. He also serves as Co-Chair for the Cross-Sector Advisory Board on Child Refugee Health.

Jean L. Raphael, MD, MPH is the Director of the Center for Child Health Policy and Advocacy at Texas Children's Hospital and an Associate Professor of Pediatrics at Baylor College of Medicine. For this project Dr. Raphael provided feedback on study design, participated in reviews of the report, and offered policy recommendations

Christine Kovic, PhD, Associate Professor of Anthropology at the University of Houston-Clear Lake, has conducted research on the topic of human rights and migration for 20 years in the U.S. and Mexico. For this project, Dr. Kovic was involved in networking with organizations that work with migrants; conducting stakeholder interviews; carrying out site visits; analyzing data; and writing up results. She was responsible for all Spanish language interviews, including family interviews and focus groups.

8 APPENDICES

8.1 Appendix-1: Interview guidelines

Verify Recruitment Status: Choose an item.
Date of Recruitment: Click or tap to enter a date.
Verify Consent: Choose an item.
Date of Consent: Click or tap to enter a date.

Unique ID Click or tap here to enter text.
Interview Date Click or tap to enter a date.
Interviewer Initials Click or tap here to enter text.
Interviewer physically initials that informed consent was given: _____

CHILD REFUGEE HEALTH STUDY (PHONE SURVEY OF EXPERTS)

Respondent Type	Check:	Use Survey:	Unique ID Begins:
ICE Facility Director, Manager, Staff, including health professionals	☐	A	A
HHS Facility Director, Manager, Staff, including health professionals	☐	A	Aa
Health Professionals: Non-ICE/HHS Facility Only	☐	B	B
NGOs/Advocates/Service Providers	☐	C	C
Policy-makers (government sector)	☐	D	D
Academic Professionals (not currently associated with a facility)	☐	E	E

Unique ID Click or tap here to enter text.

Instructions: *Complete all items in this cover page. Select the appropriate survey and enter a unique numerical ID* on this face sheet and survey. *Save the survey file with as <Type-ID-date> before interview. Save file after each Item. Enter Start Time* Click or tap here to enter text.

Interviewer: Thank you for granting this interview. You will be asked five sets of questions on the topic of the health of child refugees. We anticipate the interview will take approximately one hour.

From your experience and knowledge, what is the most important issue for child refugee health? Click or tap here to enter text.

ITEM 1: EXPERIENCE OF MIGRANT CHILDREN UPON APPREHENSION AND DETAINMENT

From your [agency's/department's/organization's] perspective, what is the typical story of what happens when an undocumented child [he/she] is [encountered/apprehended/processed/admitted] him/her? Click or tap here to enter text.

Probe for:

- Specific regulations, practices, statures/ordinances, executive orders, etc. that specify how they deal with children.
- Variation by accompanied/unaccompanied, child age/sex, contiguous/non-contiguous country of origin
- Medical screening and time of screening (e.g., upon entry or otherwise). What are the components of the screening (physical exam, mental exam, lab work, etc)?
- Average and maximum length of stay
- Types of [agencies/departments/organizations/facilities] they may be transitioned to both within and outside the [agency's/department's/organization's] authority
- Challenges agency/department/organization faces in dealing with this population
- Challenges (e.g., staff, training, etc.) in implementing required policies and practices and actual practices and reasons for the challenges.

Click or tap here to enter text.

ITEM 4: HEALTH OF MIGRANT CHILDREN AND FAMILIES BEFORE AND AFTER APPREHENSON AND DETAINMENT

A. How would you describe the health status of refugee children before they are detained and processed by ICE and HHS? Click or tap here to enter text.

B. Please provide examples of specific physical and mental health conditions or illnesses that are most prevalent among this population before they are detained or processed. Click or tap here to enter text.

Probe:

- Differences in accompanied and unaccompanied
- Variation by age and sex

- Variation by nationality (Guatemalans, Hondurans, Salvadorans, Mexicans)
- Specific concerns of Indigenous populations and other ethnic/racial groups

Click or tap here to enter text.

C. How would you describe the health status of immigrant children after being release into the community with a relative, guardian or sponsor after being processed, released, and or left by an ICE or HHS facility?Click or tap here to enter text.

D. Please provide examples of specific physical and mental health conditions or illnesses that are most prevalent among this population after being released.Click or tap here to enter text.

Probe:

- Differences between accompanied and unaccompanied children
- Variation by age and sex
- Injuries or infectious diseases or trauma that developed while at an ICE or HHS facility or on the journey through Mexico.
- Adequacy of the health services received
- Availability of health records from services received during stay at ICE and HHS facility
- Access to appropriate care for people with disabilities

Click or tap here to enter text.

E. When these children need physical or mental healthcare, after being released from ICE or HHS facilities, where do they go? Click or tap here to enter text.

F. What barriers do they face in seeking care?Click or tap here to enter text.

Probe:

- Availability of Spanish speaking providers or availability of interpreters (for Spanish or indigenous languages)
- Distance and transportation
- Coverage and costs
- Cultural behaviors re health and health providers
- Fear, due to immigration status (or due to other factors)

Click or tap here to enter text.

G. What community-based programs, if any, have been made available for routine health screening for these children and their families? Click or tap here to enter text.

ITEM 5: MIGRANT EXPERIENCE

Now I'd like to ask you some general questions about the experience of migrants from Mexico and Central America.

A. From your experience/research, what are the main reasons that cause people from Mexico and Central America to immigrate? Click or tap here to enter text.
B. From your experience/research, what are the main causes for the recent immigration of Mexican and Central American children? Click or tap here to enter text.
C. Where do people from Mexico and Central America immigrate to (in the U.S.)? Click or tap here to enter text.
   Probe for reason: Click or tap here to enter text.
D. How would you describe access to health care in Mexico and Central America, especially for children? Click or tap here to enter text.
   Probe: What about access to health care for Central Americans passing through Mexico? Click or tap here to enter text.

Is there anything you would like to add regarding child refugee health? Thank you for your time.

Appendix-2: The Treatment of Undocumented Child Migrants

Documents have been summarized for this report

8.1.1 Declaration on the Rights of the Child[x]

Principle 1: Child shall enjoy all the rights of the Declaration without distinction or discrimination on account of race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status, whether of the child or the family.
Principle 2: Child shall enjoy special protection and the opportunity to develop physically, mentally, morally, spiritually and socially in a healthy and normal manner and in conditions of freedom and dignity. The best interests of the child shall be paramount.
Principle 4: Child shall benefit from social security, be entitle to grow and develop in health, have special care and protection (to the child and mother, including pre-natal and post-natal care), and have the right to adequate nutrition, housing, recreation, and medical services.
Principle 5: Special treatment provided to a child who is physically, mentally, or socially handicapped, including education and care.
Principle 6: Children shall, when possible, grow up in the care and responsibility of parents and only under exceptional circumstances be separated from a mother. Society and public authorities have the duty to extend care to children without a family and to those without adequate support. State and other assistance shall be paid toward the maintenance of children of large families if desirable.
Principle 7: Elementary education shall be free and compulsory. The best interests of the child shall be the guiding principle of those responsible for the child's education. The child shall have full opportunity for play and recreation.
Principle 8: The child shall in all circumstances be among the first the receive protection and relief.
Principle 9: The child shall be protected against all forms of neglect, cruelty, and exploitation.
Principle 10: The child shall be protected from practices that foster racial, religious, or any other form of discrimination.

8.1.2 Flores Settlement Agreement[xi]

Applies to Department of Homeland Security (DHS) and Health and Human Services' Office of Refugee Resettlement (ORR).
All migrant children in the legal custody of DHS or ORR be held in the least restrictive setting appropriate to their age and special needs, generally, in a non-secure facility licensed to care for dependent, as opposed to delinquent, minors.
All migrant children in the legal custody of DHS or ORR be released from custody without unnecessary delay to a parent, legal guardian, adult relative, individual specifically designated by the parent, licensed program, or, alternatively, an adult seeking custody deemed appropriate by the responsible government agency.

8.1.3 Childcare Licensing Ruling[xii]

Judge Karin Crump invalidated the Texas regulation that allowed for the licensure of Karnes and Dilley. According to the court, the regulation allowing for licensing of family detention centers "contravenes Texas Human Resources Code § 42.002(4) and runs counter to the general objectives of the Texas Human Resources Code." The regulation would have also authorized licensure without compliance with fundamental state minimum standards that ordinarily apply to child care facilities -- including a standard prohibiting children from sharing bedrooms with unrelated adults.[xiii]

[x] https://www.unicef.org/malaysia/1959-Declaration-of-the-Rights-of-the-Child.pdf

[xi] https://lirs.org/wp-content/uploads/2014/12/Flores-Family-Detention-Backgrounder-LIRS-WRC-KIND-FINAL1.pdf

[xii] Grassroots Leadership, Inc., et al., v Texas Department of Family and Protective Services (DFPS), et al., and Correction Corporation of America, Inc., and The GEO Group, Dec 2, 2016. http://grassrootsleadership.org/sites/default/files/uploads/gli_v._dfps_final_judgment.pdf

[xiii] http://grassrootsleadership.org/releases/2016/12/breaking-texas-court-blocks-licensing-family-detention-camps-childcare-facilities

8.1.4 Flores Settlement Agreement and DHS Custody: Compliance Table[xiv]

***Flores* exception to release**	**DHS Noncompliance**
1. Where the detention of a particular child is required to secure his or her timely appearance before DHS/HHS or immigration court.	Data shows the vast majority of children appear for their court proceedings, as such accompanied children in family detention should be afforded release opportunities.[xv]
OR 2. Where the continued detention is required to ensure the child's safety or the safety of others.	Research overwhelmingly demonstrates that Central American children in DHS family detention facilities are fleeing human rights abuses and violence and do not pose any safety risk to their families' communities in the U.S. DHS' opposition to bond in these cases are misguided and incorrectly rely on national security agreements. DHS has argued for this national security justification for family detention misapplying the case *In re D-J-,* in which the government argued that reports or rumors of successful entries could encourage further mass migration attempts and thereby endanger national security.[xvi] All of these children and families are not "successful entries" as there were apprehended or turned themselves in. Asylum-seeking migrants should never be deterred from seeking safety and punished by being placed in detention simply because other migrants form their country are pursuing their legal right to seek legal protection in another country. Furthermore, given the grave mental and medical health concerns surrounding the detention of children, release together with the parent should be seen as in the best interest of the child unless exceptional circumstances exist.

8.1.5 Framework for Considering the Best Interests of Unaccompanied Children[xvii]

A practical guide for considering a child's best interests as part of any decision about that child, in a matter that is consistent with existing immigration law. The document envisions that each decision maker would consider a child's best interests as part of each decision along with the continuum of a child's care – from apprehension, to custody, to release, to a decision on the child's legal claim, including the possibility of repatriation – and articulates specific factors to address as part of those decisions.

8.1.6 Fair Day in Court for Kids Act of 2016[xviii]

Would have required the government to appoint counsel to vulnerable immigrants, including unaccompanied children[xix].

8.1.7 American Academy of Pediatrics Position Statements

AAP Council on Community Pediatrics. Policy Statement: Providing Care for Immigrant, Migrant, and Border Children. Pediatrics, 2013, 131(6): e2028-34.[xx]	This statement provides a basic framework for serving and advocating for all immigrant children, with a particular focus on low-income and vulnerable populations. Recommendations include actions needed within and outside the health care system, including expansion of access to high-quality medical homes with culturally and linguistically effective care as well as education and literacy programs.

[xiv] "Key Flores Provisions and DHS Noncompliance," in *Flores Settlement Agreement and DHS Custody*, https://lirs.org/wp-content/uploads/2014/12/Flores-Family-Detention-Backgrounder-LIRS-WRC-KIND-FINAL1.pdf

[xv] *New Data on Unaccompanied Children in Immigration Court*, (Transactional Records Access Clearinghouse at Syracuse University July 15 2014) available at: http://trac.syr.edu/immigration/reports/359/

[xvi] *In re D-J-,* I. & N. Dec. 572 (BIA 2003)

[xvii]https://www.gcir.org/sites/default/files/resources/2016%20Young%20Center%20Framework%20for%20Considering%20Best%20Interests%20of%20Unaccompanied%20Children.pdf

[xviii] Fair Day in Court for Kids Act of 2016 (S. 2540), https://www.congress.gov/bill/114th-congress/house-bill/4646

[xix] https://www.aclu.org/sites/default/files/field_document/fairday_onepager.pdf

[xx] http://pediatrics.aappublications.org/content/early/2013/04/30/peds.2013-1099

Brief of Educators and Children's Advocates as *Amici Curiae* In Support of Petitioners[xxi].	Argument in short: Lifting the [DAPA and DACA] injunction would benefit millions of U.S. citizen and LPR children by providing them with the family stability and security that is essential in supporting their healthy development, educational attainment, emotional well-being, and economic stability. It would also advance important educational opportunities for the DACA-eligible population.

8.2 Appendix-3: Child Migrant Legislation

Bill Title: Relating to the establishment of the task force on asylum-seeking children.
Download: https://legiscan.com/TX/text/HB278/id/1434313/Texas-2017-HB278-Introduced.html

Bill Title: Relating to the expanding eligibility for medical assistance to certain persons under the federal Patient Protection and Affordable Care Act and ensuring the provision of quality care under the effectiveness of the medical assistance program.
Download: http://www.legis.state.tx.us/tlodocs/84R/billtext/html/HB00977I.htm

Bill Title: relating to Medicaid eligibility for certain residents.
Download: http://www.legis.state.tx.us/tlodocs/84R/billtext/pdf/HB03934I.pdf#navpanes=0

Bill Title: relating to Medicaid eligibility for certain residents.
Download: http://www.capitol.state.tx.us/tlodocs/85R/billtext/pdf/SB00011I.pdf#navpanes=0

[xxi] http://downloads.aap.org/DOFA/US%20v.%20Texas%20Amicus.pdf

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